

**Agency Proposed Budget**

The following table summarizes the total executive budget proposal for the agency by year, type of expenditure, and source of funding.

Agency Proposed Budget								
Budget Item	Base Budget Fiscal 2004	PL Base Adjustment Fiscal 2006	New Proposals Fiscal 2006	Total Exec. Budget Fiscal 2006	PL Base Adjustment Fiscal 2007	New Proposals Fiscal 2007	Total Exec. Budget Fiscal 2007	Total Exec. Budget Fiscal 06-07
FTE	2,755.01	(28.83)	3.00	2,729.18	(28.83)	13.00	2,739.18	2,739.18
Personal Services	114,038,582	6,294,251	298,262	120,631,095	6,331,035	748,465	121,118,082	241,749,177
Operating Expenses	88,621,395	7,621,094	7,121,364	103,363,853	7,982,391	9,433,669	106,037,455	209,401,308
Equipment	376,355	51,000	85,000	512,355	36,000	0	412,355	924,710
Capital Outlay	0	0	0	0	0	0	0	0
Grants	42,470,810	3,268,515	2,354,918	48,094,243	3,761,327	3,161,061	49,393,198	97,487,441
Benefits & Claims	821,366,107	109,768,588	46,809,921	977,944,616	155,528,088	63,405,314	1,040,299,509	2,018,244,125
Transfers	0	0	0	0	0	0	0	0
Debt Service	598,806	0	0	598,806	0	0	598,806	1,197,612
<b>Total Costs</b>	<b>\$1,067,472,055</b>	<b>\$127,003,448</b>	<b>\$56,669,465</b>	<b>\$1,251,144,968</b>	<b>\$173,638,841</b>	<b>\$76,748,509</b>	<b>\$1,317,859,405</b>	<b>\$2,569,004,373</b>
General Fund	248,448,589	44,868,784	2,864,010	296,181,383	56,612,449	2,306,765	307,367,803	603,549,186
State/Other Special	36,553,605	7,310,064	17,590,210	61,453,879	9,140,977	15,825,333	61,519,915	122,973,794
Federal Special	782,469,861	74,824,600	36,215,245	893,509,706	107,885,415	58,616,411	948,971,687	1,842,481,393
<b>Total Funds</b>	<b>\$1,067,472,055</b>	<b>\$127,003,448</b>	<b>\$56,669,465</b>	<b>\$1,251,144,968</b>	<b>\$173,638,841</b>	<b>\$76,748,509</b>	<b>\$1,317,859,405</b>	<b>\$2,569,004,373</b>

**Agency Description**

The Department of Public Health and Human Services (DPHHS) administers a wide spectrum of programs and projects, including: welfare reform - Families Achieving Independence in Montana (FAIM), Medicaid, foster care and adoption, nursing home licensing, long-term care, aging services, alcohol and drug abuse programs, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health functions (such as communicable disease control and preservation of public health through chronic disease prevention).

The department is also responsible for all state institutions except prisons. DPHHS facilities include: Montana State Hospital, Warm Springs; Montana Mental Health Nursing Care Facility, Lewistown; Montana Chemical Dependency Center, Butte; Eastern Montana Veterans' Home, Glendive; Montana Veterans' Home, Columbia Falls; and Montana Developmental Center, Boulder.

**Agency Highlights**

Department of Public Health and Human Services (DPHHS)	
Major Budget Highlights	
<ul style="list-style-type: none"> <li>Total funding for the department increases \$334 million or 15 percent when the 2005 and 2007 biennia are compared. General fund support increases \$80 million or 16 percent over the same time period</li> <li>The majority (\$372 million) of the \$434 million increase over the FY 2004 base budget is in spending due to Medicaid services increases <ul style="list-style-type: none"> <li>Total executive request for Medicaid services is \$1.3 billion over the 2007 biennium</li> </ul> </li> <li>General fund for Medicaid match increases \$55 million over the biennium due to the loss of the enhanced federal match rate (\$28 million) in FY 2004 and annual adjustments that reduce the federal match rate during the 2007 biennium (\$27 million)</li> <li>The executive requests supplemental appropriations in FY 2005 totaling \$1.9 million general fund, including \$1.1 million for Child and Family Services Division and \$0.8 million for the Child Support Enforcement Division</li> </ul>	

<ul style="list-style-type: none"> <li>• Food Stamp benefit costs, which are entirely federally funded, are expected to exceed \$100 million annually by the end of the 2007 biennium</li> <li>• Major executive initiatives include: <ul style="list-style-type: none"> <li>• Medicaid redesign proposals including: <ul style="list-style-type: none"> <li>• Three separate Medicaid waiver programs</li> <li>• Expansion of health services to low income adults with a mental illness, children with a serious emotional disturbance transitioning to adult services, and potentially to persons who are unable to purchase private health insurance (Montana Comprehensive Health Association – state high risk pool)</li> </ul> </li> </ul> </li> <li>• Developmental Disabilities System Redesign</li> <li>• Expansion of PACT (Program for Assertive Community Treatment) <ul style="list-style-type: none"> <li>• Initiative to more than double community services for persons with a severe and disabling mental illness from FY 2004 base levels</li> </ul> </li> <li>• Diversion of Tobacco settlement proceeds from tobacco prevention and control to continue services authorized by a one-time diversion during the 2005 biennium</li> <li>• Expansion of the number of children covered in the Children's Health Insurance Program (CHIP) <ul style="list-style-type: none"> <li>• Use of \$4 million in private donations as a source of state match over the 2007 biennium</li> </ul> </li> <li>• Initiative that potentially anticipates that the revenue from the \$1 per pack of cigarette tax increase would be used in place of donations</li> <li>• Development of children's system of care – for early childhood development and for children who require services from more than one state agency</li> </ul>
<b>Major LFD Issues</b>
<ul style="list-style-type: none"> <li>• Redesign of the developmental disability service delivery system will have significant impacts on consumers, providers and the department, and a number of policy decisions that the legislature may wish to influence are under consideration by the department</li> <li>• Medicaid redesign is proposed which: <ul style="list-style-type: none"> <li>• Requests several waivers, with the major waiver still a concept in flux</li> <li>• Relies on permanent diversion of tobacco settlement revenue from tobacco prevention and control</li> </ul> </li> <li>• Medicare Modernization Act may have significant impacts on DPHHS expenditures and workload that are not included in the executive budget</li> <li>• The Medicare Modernization Act may offset a portion of state employee health plan payment of retirees' prescription costs</li> <li>• <u>Travis D.</u> litigation settlement agreement signed in February 2004, has implications for the developmental disabilities system and potential implications related to agency-wide administration of programs</li> <li>• Systems of care for children and children's mental health issues related to:</li> </ul>

- Funding flexibility
- Integration of budget proposals into the system
- Coordination between Service Area Authorities and Kids Management Authorities with regard to planning for children's mental health issues
- The legislature may want to exercise interim oversight of system development

The 2007 biennium executive budget request for DPHHS is \$434 million higher than the FY 2004 base budget. Most of the growth (\$372 million) is for Medicaid service increases. Operating costs increase about \$34 million and personal services funding grows a net \$14 million. Operating cost increases are due to changes in professional and consulting fees, and \$1.6 million for the biennium for bed tax fees at the Montana Developmental Center.

DPHHS is funded by general fund, state special revenue, and federal funds. The percentage of general fund remains relatively constant, providing 23.3 percent of the FY 2004 base budget and 23.5 percent of the 2007 biennium budget, although general fund outlays increase \$105 million in the 2007 biennium. General fund changes are primarily related to Medicaid match rate changes and to Medicaid caseload and service utilization changes.

State special revenue increases from 3.4 to 4.8 percent over the same time period and federal funds decrease from 73.3 to 71.7 percent. The increase in state special revenue support is due in part to the diversion of a portion of the tobacco settlement proceeds to a state special revenue fund used to support department programs. Because the legislation authorizing this diversion terminated at the end of the 2005 biennium, this funding was not included in the base budget for the department. The executive proposes continuation of this diversion of tobacco settlement proceeds. Issues related to the use of tobacco settlement proceeds are discussed later in this narrative.

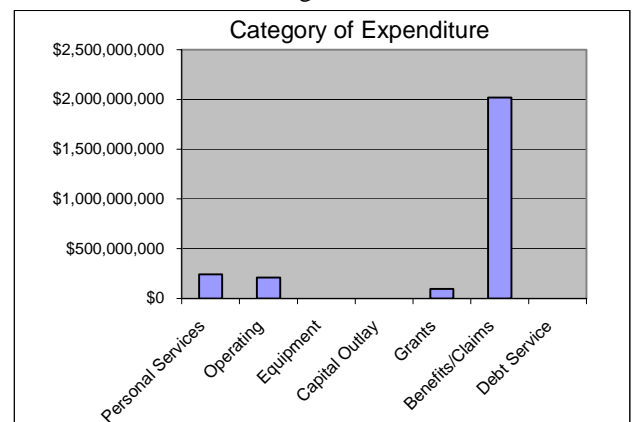
As illustrated in Figure 1 the majority of the department funding (almost 80 percent) supports benefit and claims costs paid on behalf of individuals. Personal services comprises the next largest category of expenditure (9 percent) for the department. The costs of staff at the six state institutions operated by the department account for 33 percent of the personal services costs.

#### Budget Changes by Fund Type

General fund support for the department increases due to:

- Caseload and service changes
  - Medicaid - \$33.2 million for the biennium
  - Subsidized adoption - \$2.7 million for the biennium
  - Program for Assertive Community Treatment (PACT) for persons with a serious and disabling mental illness - \$1.6 million for the biennium
  - Foster care - \$0.8 million for the biennium. However, the department has indicated the executive budget is understated by about \$1.4 million for the biennium
- Discontinuation of the enhanced federal Medicaid match rate - \$28.0 million for the biennium
- Decrease in the federal Medicaid match rate for FY 2006 and 2007 - \$27 million for the biennium
- Institutional costs that adjust for overtime, holidays worked, and differential pay as well as inflation in medical costs, utilities, and food
  - Montana State Hospital - \$3.9 million for the biennium
  - Montana Developmental Center (MDC) – \$1.1 million for the biennium
  - MDC continuation of bed tax - \$1.6 million for the biennium

Figure 1



General fund increases are slightly offset (\$1.6 million) due to the continuation of the across-the-board personal services reduction included in the 2003 biennium budget by the legislature.

State special revenue support for the department increases due to:

- Continuation of hospital provider tax to increase Medicaid payments to hospitals - \$17.7 million for the biennium
- Continued diversion of a portion of the tobacco settlement proceeds from tobacco control and prevention to other uses - \$11.9 million for the biennium
- Nursing home intergovernmental transfer (IGT) increase where county owned nursing homes make a payment to DPHHS to draw down additional federal Medicaid funds to provide higher Medicaid nursing home rates - \$3.8 million for the biennium
- Diversion of tobacco settlement proceeds from Children's Health Insurance Program (CHIP) match to Medicaid - \$2.7 million for the biennium
- Annualization of nursing home fee - \$2.3 million for the biennium
- Medicaid caseload, Health Resources Division - \$2.3 million for the biennium
- Expand "Nurse First" - \$2.0 million for the biennium

Federal funds increase due to:

- Caseload and service changes
  - Medicaid programs
    - Medicaid primary care - \$68.9 million for the biennium
    - Indian Health Services - \$25.2 million for the biennium
    - School based services - \$16.0 million for the biennium
    - Medicare Buy In - \$4.6 million for the biennium
    - Home based services - \$2.4 million for the biennium
    - Children's mental health - \$2.5 million for the biennium
    - Adult mental health - \$4.2 million
    - Breast and cervical cancer - \$1.6 million
    - Nursing home care - \$1.0 million
  - Food stamp benefits - \$44.5 million for the biennium
  - Continuation of hospital provider tax - \$42.1 million
  - Medicaid redesign, Health Insurance Flexibility and Accountability (HIFA) waiver - \$20 million
  - Child care funding transferred from TANF funds - \$13.8 million for the biennium
  - Temporary Assistance for Needy Families (TANF) cash assistance - \$8.1 million for the biennium
- Increases in federal categorical grants
  - Public health - \$7.1 million
  - Emergency preparedness - \$4.2 million
  - Energy and commodity assistance - \$1.5 million
- Requested increases in expenditure of federal TANF funds for purposes other than cash assistance - \$ 7.7 million

Federal funds growth is partially offset by a \$28 million decrease over the 2007 biennium due to the reductions in the federal Medicaid match rate.

#### *Comparison of 2007 and 2005 Biennia Funding by Division*

Figure 2 illustrates the 2005 and 2007 biennia funding by division within the department. General fund support for 6 divisions increases more than 10 percent. The largest percentage increase (144 percent) is for the Child Support Enforcement Division, although the dollar increase is only \$780,000. The largest dollar increase, \$43.3 million, occurs in the Health Resources Division, which administers the largest Medicaid programs.

**Figure 2**  
**Comparison of Funding By Division**  
**2005 and 2007 Biennia**

Division	2005 Biennium		2007 Biennium		Percent Increase	Percent Increase
	General Fund	Total Funds	General Fund	Total Funds	Gen. Fund	Total Funds
Human & Comm. Services	\$44,764,961	\$370,120,103	\$47,334,390	\$438,478,481	5.7%	18.5%
Child & Family Services	40,970,711	96,586,841	48,533,975	106,453,333	18.5%	10.2%
Director's Office	2,422,636	5,895,720	2,385,576	25,937,530	-1.5%	339.9%
Child Support Enforcement	542,473	17,220,414	1,322,785	19,416,258	143.8%	12.8%
Fiscal Services	4,074,967	10,379,518	4,352,022	11,723,600	6.8%	12.9%
Public Health and Safety	3,759,373	92,875,325	4,218,323	103,950,949	12.2%	11.9%
Quality Assurance	4,142,006	15,403,049	4,024,275	16,323,309	-2.8%	6.0%
Operations & Technology	18,156,652	54,236,564	18,077,377	55,158,582	-0.4%	1.7%
Disability Services	85,308,210	249,954,579	89,714,762	256,307,231	5.2%	2.5%
Health Resources	160,034,277	755,825,704	203,378,331	936,379,139	27.1%	23.9%
Senior & Long-term Care	80,632,162	411,212,684	94,465,796	424,142,452	17.2%	3.1%
Addictive & Mental Disorders	<u>75,702,771</u>	<u>155,089,520</u>	<u>85,741,574</u>	<u>174,733,509</u>	<u>13.3%</u>	<u>12.7%</u>
Total	<u>\$520,511,199</u>	<u>\$2,234,800,021</u>	<u>\$603,549,186</u>	<u>\$2,569,004,373</u>	<u>16.0%</u>	<u>15.0%</u>

Total funds increase more than 10 percent in 8 divisions with the largest percentage increase (339 percent) occurring in the Director's Office due to the inclusion of the Medicaid redesign proposal. The largest dollar increase (\$180 million) occurs in the Health Resources Division due to growth in Medicaid related costs. Funding for the Human and Community Services Division rises \$68 million due to increases in federal funding, primarily in food stamp benefit costs, transfer of TANF funds to child care, and increases in spending of federal TANF funds.

### Funding

The following table summarizes funding for the agency, by program and source, as recommended by the executive. Funding for each program is discussed in detail in the individual program narratives that follow.

Total Agency Funding 2007 Biennium Executive Budget					
Agency Program	General Fund	State Spec.	Fed Spec.	Grand Total	Total %
02 Human And Community Services	\$ 47,334,390	\$ 1,219,147	\$ 389,924,944	\$ 438,478,481	17%
03 Child & Family Services	48,533,975	2,906,240	55,013,118	\$ 106,453,333	4%
04 Director'S Office	2,385,576	596,441	22,955,513	\$ 25,937,530	1%
05 Child Support Enforcement	1,322,785	5,066,536	13,026,937	\$ 19,416,258	1%
06 Fiscal Services Division	4,352,022	706,006	6,665,572	\$ 11,723,600	0%
07 Public Health & Safety Div.	4,218,323	12,862,095	86,870,531	\$ 103,950,949	4%
08 Quality Assurance Division	4,024,275	915,700	11,383,334	\$ 16,323,309	1%
09 Operations & Technology	18,077,377	2,232,735	34,848,470	\$ 55,158,582	2%
10 Disability Services Division	89,714,762	3,688,372	162,904,097	\$ 256,307,231	10%
11 Health Resources Division	203,378,331	37,721,209	695,279,599	\$ 936,379,139	36%
22 Senior & Long-Term Care	94,465,796	38,101,627	291,575,029	\$ 424,142,452	17%
33 Addictive & Mental Disorders	<u>85,741,574</u>	<u>16,957,686</u>	<u>72,034,249</u>	<u>\$ 174,733,509</u>	<u>7%</u>
Grand Total	<u>\$ 603,549,186</u>	<u>\$ 122,973,794</u>	<u>\$ 1,842,481,393</u>	<u>\$ 2,569,004,373</u>	<u>100%</u>

DPHHS is funded by a combination of general fund, state special revenue, and federal funds. General fund provides almost 24 percent of the 2007 biennium budget, while state special revenue and federal funds provide about 4 and 72 percent, respectively.

Four divisions receive 80 percent of the department funding. Funding for the Health Resources Division, which administers the largest Medicaid program, equates to more than 36 percent of the department funding. Senior and Long Term Care and Human and Community Services divisions each account for about 17 percent of total department funding. Disability Services Division comprises 10 percent of the total.

A similar split is exhibited in the allocation of the general fund. The 4 divisions listed above comprise 72 percent of the department general fund budget and when the Addictive and Mental Disorders Division is combined with these 4 divisions the total percent of the general fund budget represented increases to 86 percent. The Human and Community Services Division, while second largest in total funds, is sixth largest in general fund support.

### Biennial Budget Comparison

The following table compares the executive budget request in the 2007 biennium with the 2005 biennium by type of expenditure and source of funding. The 2005 biennium consists of actual FY 2004 expenditures and FY 2005 appropriations.

Budget Item	Present Law Fiscal 2006	New Proposals Fiscal 2006	Total Exec. Budget Fiscal 2006	Present Law Fiscal 2007	New Proposals Fiscal 2007	Total Exec. Budget Fiscal 2007	Total Biennium Fiscal 04-05	Total Exec. Budget Fiscal 06-07
FTE	2,726.18	3.00	2,729.18	2,726.18	13.00	2,739.18	2,755.01	2,739.18
Personal Services	120,332,833	298,262	120,631,095	120,369,617	748,465	121,118,082	233,244,240	241,749,177
Operating Expenses	96,242,489	7,121,364	103,363,853	96,603,786	9,433,669	106,037,455	175,929,841	209,401,308
Equipment	427,355	85,000	512,355	412,355	0	412,355	2,196,210	924,710
Capital Outlay	0	0	0	0	0	0	28,398	0
Grants	45,739,325	2,354,918	48,094,243	46,232,137	3,161,061	49,393,198	87,121,936	97,487,441
Benefits & Claims	931,134,695	46,809,921	977,944,616	976,894,195	63,405,314	1,040,299,509	1,735,176,425	2,018,244,125
Transfers	0	0	0	0	0	0	0	0
Debt Service	598,806	0	598,806	598,806	0	598,806	1,102,971	1,197,612
Total Costs	\$1,194,475,503	\$56,669,465	\$1,251,144,968	\$1,241,110,896	\$76,748,509	\$1,317,859,405	\$2,234,800,021	\$2,569,004,373
General Fund	293,317,373	2,864,010	296,181,383	305,061,038	2,306,765	307,367,803	520,511,199	603,549,186
State/Other Special	43,863,669	17,590,210	61,453,879	45,694,582	15,825,333	61,519,915	86,194,813	122,973,794
Federal Special	857,294,461	36,215,245	893,509,706	890,355,276	58,616,411	948,971,687	1,628,094,009	1,842,481,393
Total Funds	\$1,194,475,503	\$56,669,465	\$1,251,144,968	\$1,241,110,896	\$76,748,509	\$1,317,859,405	\$2,234,800,021	\$2,569,004,373

General fund support for the department increases 16 percent when the 2005 and 2007 biennia are compared. This growth is primarily due to increases in state match for Medicaid due to: discontinuation of the enhanced federal Medicaid rate, reductions in the federal Medicaid rate that are expected in FY 2006 and 2007, caseload increases, and service utilization. State special revenue support for the department increases almost 43 percent due to the request to continue the temporary diversion of tobacco settlement proceeds from tobacco control and prevention that was authorized by the 2003 Legislature, to fund other DPHHS programs. Since this diversion was temporary, the tobacco settlement state special revenue appropriations were removed from the base budget, but are included in the 2007 biennium, overstating the change. Federal funds increase due to increases in caseload including food stamp benefits (\$44.5 million), Medicaid, and other. A number of federal categorical grants also increase.

The cost of benefits and claims rises 16 percent when the two biennia are compared, primarily due to caseload increases for the food stamp, Medicaid, foster care, and subsidized adoption programs. Grant costs increase 12 percent over the same time period due to increases in the child and adult food care program and various categorical grants. Operating costs increase 19 percent due to increases in consulting and professional services and taxes (\$1.6 million for MDC bed day utilization fee).

### Supplemental Appropriation

The executive budget indicates that supplemental appropriations will be requested for two areas within DPHHS:

- Child and Family Services Division (CFSD), \$1.1 million general fund
- Child Support Enforcement Division (CSED), \$0.8 million general fund

### Child and Family Services

The executive anticipates a FY 2005 general fund shortfall of \$3.7 million in CFSD and hopes to mitigate \$2.6 million of this shortfall, thus requiring a supplemental appropriation of \$1.1 million. This shortfall is primarily due to a reduction in the number of children eligible for federal foster care and adoption funding under Title IV-E of the Social Security Act. DPHHS staff indicates that the division budget for FY 2005 was based upon the assumption that about 60 percent of the

children served would be eligible for federal Title IV-E funding. Due to a number of compliance issues that were identified through internal review of case files and a federal IV-E eligibility review, currently only about 38 percent of the children served by the division are eligible for federal Title IV-E funds.

Division staff indicates the compliance issues are the result of both increased diligence in review of case files and changes in federal interpretation of the Title IV-E requirements. Surrounding states such as North and South Dakota and Utah have Title IV-E eligibility rates of about 50 percent. CFSD believes that these states are comparable to Montana and is working to achieve a comparable Title IV-E eligibility ratio. The division is taking a multi-pronged approach to the issue and is working with county attorneys, judges, and within the division to address this issue.

In November 2004, CFSD notified providers that a number of costs savings measures, including reductions in foster care support services, were now in effect. Support services being reduced include clothing allowances, respite care, and transportation. In addition to reductions in foster care costs, the division has also implemented measures such as a hiring freeze, travel reductions, overtime reductions, and a freeze on equipment purchases, in an effort to reduce the projected general fund deficit. To date, cost reductions to mitigate the projected deficit have only been implemented in the CFSD. The department does not plan to reduce services to beneficiaries in other programs. However, if necessary, agency-wide administrative cost reductions such as a hiring freeze and travel reductions may be implemented.

In addition to impacting the FY 2005 general fund expenditure levels, the decrease in the Title IV-E eligibility rate was not included in the budget proposed for the 2007 biennium. Currently, CFSD anticipates that a greater than anticipated increase in the foster care caseload, combined with the decrease in Title IV-E eligibility, will result in an increased general fund requirement for the 2007 biennium of about \$1.4 million when compared to the executive budget.

Department staff is monitoring Title IV-E eligibility and the projected general fund deficit on a monthly basis and has indicated they will apprise legislative staff of the status of this issue at least monthly.

#### *Child Support Enforcement*

The executive also anticipates a FY 2005 shortfall of \$857,058 in the CSED. Because these funds are matched with federal funds at the rate of \$2 federal for each state \$1 expended, the actual potential funding impact to the division is about \$2.5 million. Additional general fund support for CSED is requested because state special revenue funds are not expected to be adequate to sustain the operations of the division. State special revenue funds supporting CSED come from the retention of a share of child support collections on behalf of cash assistance recipients, and federal incentive funds. Both sources of funds have been declining and the issue of funding for CSED has been considered by the legislature for the past several biennia. For a discussion of CSED funding and related issues, please refer to the program narrative for that division.

### **Summary of LFD Budget Analysis Issues**

#### *Total Medicaid*

Medicaid services expenditures total \$1.5 billion, including \$330 million general fund, in the 2007 biennium. Figure 3 shows the Medicaid services base budget expenditures compared to the executive budget request by division and by major Medicaid service.

**Figure 3**  
**2007 Biennium Medicaid Services Budget Request Compared to FY 2004 Base Budget\***

Division/Major Service/Biennial Total/ Compounded Rate Incr.-General Fund	FY 2004 Base		FY 2006 Executive Request		FY 2007 Executive Request		% of
	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds	Total
<b>Health Resources*</b>							
Hospital Services	\$25,797,781	\$100,405,373	\$49,839,188	\$140,224,160	\$57,324,207	\$158,885,167	21%
Hospital Utilization Fee	0	29,696,408	0	30,299,286	0	31,124,455	4%
Pharmacy Services	17,018,984	70,857,702	15,853,814	66,339,230	16,184,625	67,529,105	9%
Children's Mental Health Services	12,432,654	60,837,251	12,601,971	61,431,371	12,812,420	62,110,781	8%
Indian Health Services	0	26,652,410	0	36,232,971	0	42,246,203	6%
All Other Services	<u>13,504,375</u>	<u>73,238,133</u>	<u>14,403,245</u>	<u>84,043,052</u>	<u>14,821,547</u>	<u>86,692,923</u>	<u>12%</u>
Subtotal Health Resources	\$68,753,794	\$361,687,277	\$92,698,217	\$418,570,070	\$101,142,799	\$448,588,635	60%
<b>Senior and Long Term Care</b>							
Nursing Home Services	\$26,603,976	\$98,562,217	\$29,490,548	\$121,069,496	\$30,319,160	\$121,372,169	16%
Intergovernmental Transfer - NH**	0	13,618,158	0	19,728,049	0	23,266,500	3%
Home Based Services	6,195,731	22,845,912	6,054,708	24,829,587	6,436,031	25,647,542	3%
Community Waiver Services	<u>5,518,010</u>	<u>20,346,639</u>	<u>6,126,512</u>	<u>21,020,589</u>	<u>6,479,208</u>	<u>21,756,777</u>	<u>3%</u>
Subtotal Senior and Long Term Care	\$38,317,717	\$155,372,926	\$41,671,768	\$186,647,721	\$43,234,399	\$192,042,988	26%
Disability Services Division	13,457,879	58,152,072	17,820,899	63,023,073	17,761,100	62,523,072	8%
MT Develop. Ctr. Reimbursement	0	11,409,136	0	11,409,136	0	11,409,136	2%
Addictive and Mental Disorders	<u>5,088,665</u>	<u>29,863,249</u>	<u>8,034,497</u>	<u>35,661,198</u>	<u>8,451,793</u>	<u>36,520,690</u>	<u>5%</u>
<b>Total</b>	<b><u>\$125,618,055</u></b>	<b><u>\$616,484,660</u></b>	<b><u>\$160,225,381</u></b>	<b><u>\$715,311,198</u></b>	<b><u>\$170,590,091</u></b>	<b><u>\$751,084,521</u></b>	<b><u>100%</u></b>
2007 Biennium Increase Over Base Budget Expenditures					\$79,579,363	\$233,426,399	
FY 2004 General Fund Base			\$125,618,055		\$125,618,055		
Compounded Annual Growth Rate			13%		11%		
FY 2004 General Fund Base Adjusted for the FY 2004 Temporary			<u>(\$14,006,344)</u>		<u>(\$14,006,344)</u>		
Enhanced Federal Match Rate			\$146,219,037		\$156,583,747		
Compounded Annual Growth Rate			8%		8%		

\*The Health Resources Division did not respond to requests for information as to how the Medicaid general fund match rate change, and caseload and service utilization changes were allocated among Medicaid services that it administers. The Health Resources Division budget request lumps nearly all the changes in the hospital services function, which overstates the change in that Medicaid service and understates the change in all other services except Indian Health Services.

\*\*Medicaid intergovernmental transfer (IGT) programs are included in this table. The legislature appropriated IGT payments as one time appropriations in the event that the federal regulations regarding such transfers change. Counties provide the non federal match required to draw down the maximum allowable Medicaid payments for county operated hospitals and nursing homes.

The total biennial increase above the base budget is \$233 million total funds, including \$80 million general fund. The executive request for general fund Medicaid services changes comprises 75 percent of the total agency general fund change (\$107 million) and almost 29 percent of the total statewide general fund change (\$228 million).

Medicaid services administered by the Health Resources Division (HRD) are the largest component of the total Medicaid budget, accounting for 64 percent of total expenditures. HRD administers state plan services, or the basic medical services including hospital, pharmacy, physicians, durable medical equipment, and other services.

#### **LFD COMMENT**

Executive budget Does not Allocate Budget Increase in Health Resources Division (HRD) Among Medicaid Services – The executive budget was constructed showing base budget expenditures for Medicaid by each major type of service administered by HRD. However, the 2007 biennium increase for caseload and service utilization increases as well as funding changes due to the increase in state Medicaid matching rates was allocated almost entirely to hospital services. LFD staff requested that HRD provide the executive budget allocation by type of service, but HRD did not provide the information. The table reflects the executive request, but it is misleading, especially with respect to hospital and pharmacy services. Some of the increase allocated to hospitals should be spread among all other service components listed in Figure 3, except Indian Health Services.



The Senior and Long Term Care Division (SLTC) administers Medicaid services for the aged and physically disabled, including nursing home, home based services, and a home and community based waiver program, which in total account for 26 percent of total Medicaid service costs. Home based services are an entitlement, meaning that any Medicaid eligible person can receive the service as long as it is medically necessary. Home based services include personal assistance services, certified home health care (physical, occupational, and speech therapies, and skilled nursing services), and hospice services. Waiver services are not entitlement services and require special federal authorization to “waive” certain mandatory federal requirements. SLTC waiver services include assisted living, case management services, traumatic brain injury services, home modifications, and assistive technology (equipment, such as automatic door openers, that are not covered by regular Medicaid state plan services).

Nursing home services comprise 16 percent of the total FY 2007 Medicaid budget request, and rise to 19 percent when intergovernmental transfer (IGT) payments are added in. IGT payments are governed by federal rule. County nursing homes can send in county funds to draw down additional federal Medicaid matching payments to increase nursing home rates. IGT payments must not be diverted to fund unauthorized uses, such as road maintenance.

The Disability Services Division administers a Medicaid home and community based waiver serving developmentally disabled individuals (adults and children) and the Montana Developmental Center, which receives Medicaid reimbursement for services provided by the institution. The executive budget includes requests for increased Medicaid expenditures for the home and community based waiver to support the movement of individuals from the institution to community services and to serve individuals currently on the waiting list for services. This service delivery system is currently in the process of a significant system redesign of Medicaid funded services. A number of issues related to this redesign are discussed briefly later in this agency narrative and in more detail in the program narrative for the DSD.

The Disability Services Division also administers the Montana Developmental Center, which bills and receives Medicaid reimbursement for services provided at the institution. Medicaid reimbursements for institutional services are first used to repay bond debt with the balance after the bond repayment being deposited to the general fund as revenue. While the executive budget maintains Medicaid reimbursements for these institutional services at a constant level, it is likely that this reimbursement will decrease due to the decline in the number of individuals served at the institution in Boulder and the changing nature of individuals committed to this institution. It is likely that some of the individuals committed to the facility under criminal statutes may not be eligible for Medicaid reimbursement of services.

Addictive and Mental Disorders administers Medicaid outpatient chemical dependency services and mental health services for adults, which is the smallest portion of the FY 2007 executive request (5 percent of the total).

### ***General Fund Growth of Medicaid***

The executive general fund Medicaid budget request for the 2007 biennium increases \$79 million compared to the FY 2004 base budget. The compounded annual rate of growth is 13 percent from FY 2004 to FY 2006 and drops slightly to 11 percent from FY 2004 to FY 2007. General fund support for Medicaid grows for two reasons: 1) federal match rate changes; and 2) increases in the number of persons eligible and service utilization.

### ***Federal Medicaid Match Rate Changes***

Federal match rate changes cause Medicaid general fund costs to grow \$53 million and other programs with matching rates tied to the Medicaid rate, \$2 million, over base budget expenditures. Each 1 percent change in the federal match rate causes a \$5 million change in state matching funds. Figure 4 shows the two components of the match rate change: 1) a temporary increase in FY 2004; and 2) increases for annual adjustments during the 2007 biennium.

Figure 4

## General Fund Increase due to Federal Medicaid Rate Change

Service/Division	FY 2006	FY 2007
<b>Loss of Enhanced Federal Match in FY 2004:</b>		
Health Resources Division*	\$7,504,153	\$7,504,153
Nursing Homes - Senior/Long Term Care	2,972,470	2,972,470
Developmental Disabilities - Disability Svcs	1,726,793	1,726,793
Mental Health - Addictive/Mental Disorders	725,924	725,924
Home Based Services - Senior/Long Term Cr	569,730	569,730
Waiver Services - Senior/Long Term Care	507,274	507,274
Subtotal	\$14,006,344	\$14,006,344
<b>Annual Adjustment in Federal Match Rate:</b>		
Health Resources Division*	\$6,189,028	\$8,045,737
Nursing Homes - Senior/Long Term Care	2,447,917	3,182,292
Developmental Disabilities - Disability Svcs	1,140,119	1,561,844
Mental Health - Addictive/Mental Disorders	547,120	711,256
Home Based Services - Senior/Long Term Cr	490,189	615,730
Waiver Services - Senior/Long Term Care	417,755	543,081
Foster Care & Subsidized Adopt - CFSD**	265,392	375,104
Children's Health Insurance (CHIP)**	195,245	269,383
Subtotal	\$11,692,765	\$15,304,427
Total General Fund Increase		
Due to FMAP Changes	\$25,699,109	\$29,310,771
Biennium Total		\$55,009,880

\*Health Resources Division did not allocate the Medicaid match rate change among Medicaid services that it administers. LFD requested such information but did not receive a response from the division.

\*\*Foster care, subsidized adoption, and CHIP are not Medicaid services, but the federal match rates are used in those programs. The federal match rate for CHIP is based on a percentage of the federal Medicaid match rate.

The FY 2004 base budget general fund expenditures were about \$14 million lower due to a temporary 2.95 percent increase in the federal Medicaid match rate, authorized as part of federal fiscal relief in the Jobs and Growth Tax Relief Reconciliation Act of 2003. Additionally, about \$4 million was reverted to the general fund in FY 2003 due to this temporary increase in the federal Medicaid match rate.

The annual adjustments in the federal Medicaid match rate are determined based on changes in state per capita income compared to the national per capita income. The general fund cost increase due to annual Medicaid match rate adjustments during the 2007 biennium is \$27 million. Foster care services, including subsidized adoption, as well as the Children's Health Insurance Program (CHIP) are included in the table because federal match rates for those programs are the same as or linked to federal Medicaid match rate changes. The temporary match rate increase in FY 2004 did not apply to foster care or CHIP services.

Figure 5 shows the Medicaid and foster care services state matching rate from FY 2004 through the estimate FY 2007 rate. The CHIP match rate is a percent of the federal Medicaid match.

Figure 5

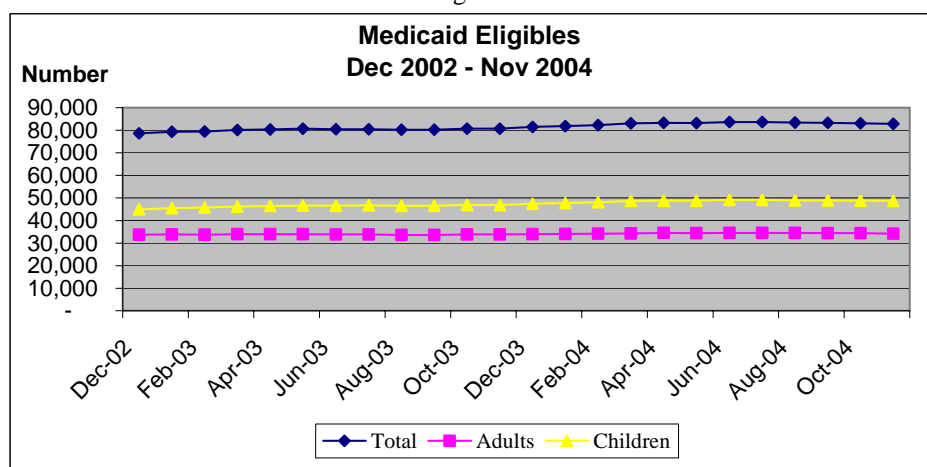
State Match Rates  
by State Fiscal Year

Year	Medicaid*	CHIP
2004	24.24	18.99
2005	28.04	19.50
2006	29.29	20.38
2007	29.92	20.91

\*Match rates for foster care and developmental disability services vary slightly (about 0.07 percent).

The number of persons eligible for Medicaid each month from December 2002 through November 2004 is shown in Figure 6. The number has gradually increased over that time period, rising from slightly fewer than 80,000 per month to about 83,000. However, over a full year there are about 110,000 persons eligible for Medicaid.

Figure 6



Children represent more than half the number of eligibles. However, the cost to cover children, unless they are disabled, is relatively inexpensive.

**LFD Staff Policy Issues**

There are several important policy issues affecting DPHHS. Some are over arching policy issues that impact more than one division in DPHHS, while some issues are significant changes within a service system.

*Medicaid Redesign*

The 2003 Legislature adopted HJ 13, which requested that the Department of Public Health and Human Services (DPHHS) undertake a study that would examine the various options available for redesigning the Montana Medicaid program, the Mental Health Services Plan (MHSP), the state Children's Health Insurance Program (CHIP), and other health programs administered by the department. HJ 13 also requested that DPHHS involve tribes in the redesign process, report periodically to legislative interim committees, and prepare a report for the 2005 Legislature outlining options that may be undertaken to redesign the health programs administered by DPHHS.

The Governor appointed a 20-member advisory council (Governor's Health Care Advisory Council), which met several times and made 18 recommendations, including the recommendation to statutorily require review on the progress toward implementation of redesign recommendations.

DPHHS adopted all but one recommendation and is preparing legislative and budget requests for the 2005 session. This summary of the redesign proposals is based on data available in November 2004. Some details may change when the proposal is submitted for legislative review in January 2005.

HIFA Waiver

One of the most important fiscal and programmatic components of the redesign recommendations is the Health Insurance Flexibility and Accountability (HIFA) waiver. This type of waiver was promulgated by the Bush administration and does not exist in federal rule or in Title XIX of the Social Security Act. A HIFA waiver must:

- Include an expansion of health care benefits for the uninsured
- Include a public/private partnership
- Be cost neutral over the five year life of the waiver (i.e. cost no more in federal Medicaid funds than would have been paid without the waiver)

Use of Existing State Funds to Leverage More Federal Medicaid Match and Expand Health Care Services

The HIFA waiver under consideration by DPHHS would "refinance" 100 percent state funded services by including those services and persons eligible for such services in the state Medicaid program, and using the state funds for those programs as state match to draw down additional federal Medicaid funds. The current proposal anticipates using between \$3.3 and \$5.3 million in state funds to generate an additional \$8 to \$12 million in federal Medicaid funds for additional health services.

The executive proposal would move portions of the services provided by and the funding for the Mental Health Services Plan (MHSP) and the Montana Comprehensive Health Association (MCHA) into the HIFA waiver. MHSP provides prescription drugs and some other services to adults with a serious and disabling mental illness who have incomes under 150 percent of the federal poverty level. The MCHA provides insurance or premium assistance to some persons who have been denied health insurance coverage.

Use of Tobacco Settlement Proceeds

The source of state funding for each of these programs is tobacco settlement proceeds. MCHA receives a portion of tobacco settlement revenue allocated by 17-7-606, MCA.

MHSP is funded with general fund and the executive proposal for the 2007 biennium, with tobacco settlement proceeds reallocated from tobacco prevention and control.

The 2003 Legislature authorized a one-time diversion of tobacco settlement proceeds from tobacco control and prevention activities to continue a number of programs, including MHSP, slated for elimination or reduction by the Governor during the 2005 biennium. The 2007 biennium executive proposal makes this temporary funding shift permanent.

HIFA Waiver Health Services Expansion

The expansion of health services in the HIFA waiver includes:

- MHSP – add physical health benefit and “refinance” prescription costs for two-thirds of MHSP recipients without other health insurance
- MCHA – expand premium assistance program and/or raise premium assistance (recently declined from 55 percent to 45 percent)
- Add services for up to 300 children with serious emotional disturbance (SED) transitioning to adult services
- Expand CHIP type coverage
  - Expansion potentially funded with Medicaid funds rather than using federal CHIP grant
  - Number of additional children to be served undetermined at this time
- Assistance for low-income working adults transitioning off Medicaid
  - Number of additional adults to be served undetermined at this time
- Sometime within the five-year life of waiver, partnership with employers for premium assistance

**LFD  
ISSUE**

Equal Protection Issue – The legislature may wish to request a legal opinion on whether the anticipated expansion of CHIP coverage for children by using federal Medicaid funds could create an equal protection issue. The equal protection issue arises with respect to the types of mental health services available to children eligible for Medicaid services compared to mental health services available to children eligible for CHIP.

During the 2003 biennium, DPHHS limited access to some Medicaid funded mental health services to children who are seriously emotionally disturbed (SED). So non SED children eligible for Medicaid, including children in foster care, do not have routine access to mental health services including outpatient counseling, care coordination, or case management.

CHIP includes coverage of some mental health services, including outpatient counseling, for all eligible children. (The executive budget also includes a proposal to expand CHIP coverage for SED children who exceed regular CHIP plan mental health service limits).

The potential equal protection concern is that higher income children in a component of the Medicaid program will have routine access to some mental health services and that lower income children, some with potential mental health issues due to abuse, neglect, and removal from their family, will not have access to the same level of benefits.

**Options**

The legislature could request a legal opinion as to the validity of this issue. If there are equal protection concerns, the legislature could consider requesting the agency offer suggestions as to how to resolve the issue including potentially:

- Offering the regular CHIP mental health benefit for all Medicaid children who are not SED
- Removing mental health benefits for CHIP eligible children unless they are SED
- Funding the CHIP expansion with federal CHIP funds only

Cost Neutrality for Federal Government

All waivers of federal Medicaid regulations must be cost neutral to the federal government, meaning that over the lifetime of the waiver, the federal Medicaid cost must be no greater than it would have been without the waiver. The DPHHS proposal must be cost neutral over a five year time period. If it is not, the state must repay excess costs to the federal government. Cost neutrality considerations have constrained some of the proposed HIFA expansions.

At this point in time, DPHHS will be allowed to use cost savings generated by an existing waiver that allows Montana to offer a “basic” package of Medicaid services to adults in the FAIM program, rather than all federally required Medicaid services. Additional cost neutrality components of the proposed waiver rely on the “logic” that Montana could have made other groups eligible for full Medicaid, but chose to limit benefits thereby saving federal funds. Finally, there will be a per person per month cap on the growth in Medicaid costs for populations covered by the waiver. If cost growth exceeds this cap, then service reductions or other changes in the waiver could be made to ensure cost neutrality.

### Other Major Redesign Proposals

There are several other redesign proposals that will come before the legislature in January. While the HIFA proposal is the most complex, other proposals, including additional Medicaid waiver proposals, are significant policy issues for legislative consideration.

#### ***Waiver of “Deeming”***

DPHHS will request a waiver of deeming, which means that parental income and assets are not considered in determining whether a child is eligible for Medicaid. Montana already has two such waivers. One provides services to children who are developmentally disabled and the other provides services to children who are physically disabled. The proposed third waiver would be used to provide services to seriously emotionally disabled (SED) children.

All children in these waivers are entitled to regular medical state plan Medicaid services. In addition, the waiver allows home and community based services that are not typically covered by Medicaid. For example, respite services for parents who care for disabled children can be covered in a waiver.

This proposal would also establish some type of cost share for families, based on their ability to pay. The cost sharing would be applied to all waivers and not just the new proposal to cover SED children.

#### ***Look Back Period for Medicaid Eligibility***

States are required by federal regulations to review transfers of assets for three years previous to the application for Medicaid eligibility. Certain asset transfers made to artificially impoverish a Medicaid applicant are illegal. This proposal would request federal approval to extend the look back period to five years rather than three.

Asset transfers are usually considered in conjunction with estate planning in order to protect family assets. Since nursing home services can quickly deplete assets, some persons shift the costs of their long-term care to Medicaid. The average Medicaid cost for a person in a nursing home is \$36,000 per year, not including one-time rate enhancements.

#### ***Dollar for Dollar Waiver***

DPHHS is also considering a dollar for dollar waiver that allows persons who purchase long-term care insurance to retain assets when eligibility for Medicaid nursing care services is considered. Under this concept, an amount of resources equal to the value of insurance paid out to the individual is disregarded in Medicaid eligibility determination. For instance, if the individual were to receive \$10,000 of long-term care insurance payout, \$10,000 of assets would be disregarded in determining financial eligibility.

#### ***Health Education***

The Medicaid redesign recommendations include two recommendations related to education. One proposal recommends general public education, including education aimed at helping students understand good health practices. The second proposal centers on education about long-term care and planning for such services.

#### ***Family Planning Waiver***

DPHHS is reviewing whether to propose a family planning waiver that can expand services to more low-income persons at a 90 percent federal match rate. Services that can be included in such a waiver are prenatal care, delivery, and medical costs for the mother, and ongoing health care for the child. The mix of services and timing of the delivery of those services has not been finalized.

#### ***Waiver to “Sever” Indian Health Services (IHS) from State Medicaid Plan***

IHS is reimbursed with 100 percent federal funds for Medicaid covered services provided to Medicaid eligible persons. However, only services allowed by the Montana Medicaid state plan are eligible for reimbursement.

During the 2003 biennium there were several changes to the state Medicaid plan that eliminated certain services from the state plan in order to avoid cost over runs and to limit general fund costs. Those actions also eliminated Medicaid reimbursement to IHS for those services.

DPHHS will attempt to sever the link between the Medicaid state plan and Medicaid eligible reimbursement for IHS services for the following reasons:

- IHS Medicaid reimbursement is 100 percent federal
- Limiting or eliminating coverage of certain Medicaid services can shift the cost to limited IHS funds
- Avoidance of higher cost state plan services received at non HIS facilities, which are partially state funded

#### ***Develop Transportation Brokerage Pilot Project***

DPHHS is developing a pilot project to determine whether persons can be well served and costs contained by coordinating travel. In some instances, there may be several persons traveling from and to the same place on the same day. Since some or all travel costs can be born by DPHHS programs, coordination may provide efficiencies. The pilot project will be implemented in a region of the state and depending on results could be extended to other or all parts of the state.

#### ***Other Recommendations***

There are several other redesign recommendations including:

- 1) Enhance third party collections – DPHHS will undertake efforts to determine whether Medicaid costs for some persons can be partially or fully offset by other insurance coverage that those persons may have such as private insurance and Medicare.
- 2) Develop a strategic plan for adult mental health services – The redesign process emphasized the need for and commitment to a long-term strategic plan for adult mental health services.
- 3) Medicaid eligibility field review – DPHHS is initiating a review of Medicaid eligibility determination to ensure that field staff applies Medicaid eligibility criteria consistently and according to state and federal policies.
- 4) Implement pharmacy cost containment – DPHHS is undertaking several measures to reduce pharmacy cost growth, including actions such as:
  - Adopting a preferred drug list and/or seeking a federal waiver to require higher co-payments for equally effective, but higher cost, drugs
  - Examining the potential of developing an evidence-based drug program to work in coordination with the preferred drug list
  - Exploring the feasibility of developing a state drug discount program
  - Examining the potential for re-importation of drugs from other countries
  - Pending the request of IHS or the tribes, seek mechanisms, including, if necessary, a 1915(b) freedom of choice waiver, to insure that IHS-eligible Medicaid participants on reservations can have their prescriptions filled at IHS or tribal facilities

#### ***Legislation for Redesign***

Four bill draft requests have been submitted to implement components of Medicaid redesign.

LC 0281 –When considering changes to the Medicaid policy or services requires DPHHS and the legislature to consider:

- Protecting those persons who are most vulnerable and most in need, as defined by a combination of economic security and medical circumstances
- Giving preference to the elimination of an entire Medicaid program or service, rather than sacrifice the quality of care for several programs or services through dilution of funding
- Giving priority to retaining those service that protect life, alleviate severe pain, and prevent significant disability

LC 0290 – Home and community based services waiver guidelines including:

- Allowing such waivers for persons with mental illness
- Allowing DPHHS to determine methods of reimbursement for waiver services
- Rewording existing statutes to enhance organization and clarity

LC 219 – Authorization for DPHHS to require recipients of home and community based Medicaid services to share in the cost of services based on their ability to pay with specific directive to review parental ability to pay if the Medicaid recipient is under the age of 18.

LC 0292 – Generally allows DPHHS to pursue a HIFA waiver as summarized in the beginning of this narrative

LC 0293 – Authorization for DPHHS to request a Medicaid waiver for SED children

### LFD ISSUE

Medicaid Redesign Cost Impact and Legislation – Several of the Medicaid redesign proposals could reduce Medicaid service costs, or at least defer the onset of costs. Cost savings could occur in a number of areas. For instance, requiring a cost share for children in a Medicaid home and community based waiver service whose families have income and resources in excess of regular Medicaid standards will help offset costs. Serving SED children in their own family and community can negate or shorten the need for higher cost out of home placements that might be paid by Medicaid. Requiring all Medicaid ineligible asset transfers to occur prior to five years of application for Medicaid benefits and implementing a dollar for dollar waiver could help lower nursing home costs. Additionally, the use of the dollar for dollar waiver should help support development of better private long-term care insurance products. Providing a limited physical health benefit for Mental Health Services Plan (MHSP) clients could improve their overall health status with potential benefits for treatment of their mental illness.

However, estimating any cost savings would be extremely difficult and fraught with the potential for error. The legislature may not be able to quantify the benefits of the Medicaid redesign proposal in monetary terms.

Most of the waiver proposals included in Medicaid redesign would be authorized through legislation. However, in order to meet pre-introduction deadlines, some of the draft bills include a broad delegation of legislative authority. The legislature may wish to request that DPHHS flesh out waiver proposals so that the legislature can ensure that its policies and direction are reflected in any authorization it grants to the department.

### *Developmental Disabilities Redesign*

The findings from a Center for Medicare and Medicaid (CMS) review and conditions of the settlement agreement in the case commonly known as Travis D. are primary catalysts for a number of changes that are underway in the Developmental Disabilities (DD) service system. This system is in the process of significant system change and evolution. Some individuals knowledgeable of the changes have equated them to implementation of mental health managed care as a reference point for others to conceptualize the significance of these changes to the system. Among the primary system changes that will be implemented are:

- Resource allocation - The process for allocation of the available funding among service recipients will change. A uniform method will be used statewide for adults and children over the age of six who are enrolled in home and community based waiver services
- Provider rates – Provider reimbursement will be based upon a published fee schedule and will be uniform statewide, rather than based upon individually negotiated contracts
- Provider billing – Providers will invoice based upon the service and volume of service units provided to a specific client, rather than billing each month for one-twelfth of a contracted amount

The changes currently being planned in the DD system impact most DD system stakeholders including consumers, consumer families, providers, and the department. Additionally, as planning is undertaken for these changes review, discussion, and change of policies occur. There are a number of significant policy issues under discussion within the department. Some of the policy decisions being made (which are discussed in more detail in the program narrative for the Disability Services Division) include:

- Assumptions, including direct care wage rates, employee benefit ratio, program administrative costs, and general administrative costs, used as the basis to establish the proposed published rate schedule
- Changes in screening criteria determining which individual is selected to enter services
- Timing of and proposed phase-in of implementation of changes

The department does not segregate elements of the system redesign between those necessary to comply with federal Medicaid requirements and those necessary to comply with the settlement agreement in the Travis D. litigation. The elements necessary to achieve both goals are intertwined. Thus, the legislature will see few if any budgetary or policy proposals that are specifically attributable to one or the other objective.

Another significant issue related to the DD system has to do with the provision of services identified in an individual's plan of care. CMS had indicated their expectation that an individual will receive all of the services identified as necessary and included in the individual client's plan of care. This expectation poses a philosophical difference with how Montana has historically administered this program. Historically, the program has been administered in a manner that attempts to provide services to as many individuals as possible even if that means that only some of the needs identified in the individual client's plan of care are met. This philosophical difference and CMS citation of this issue as a concern place the state at risk for financial penalties related to non-compliance with Medicaid requirements and to increase the financial resources to a level that assures that all of the services identified in the individual client's plan of care are provided. While no estimate of the costs to comply with this federal Medicaid requirement is available, it is anticipated that millions of dollars of additional funding would be needed to address this issue.

In addition to the system redesign that focuses on resource allocation and provider reimbursement, the DD system is also experiencing changes in the institutional population. The population being served includes individuals criminally committed to the facility as well as those committed under civil procedures. Department staff reports that in general, the population being served is becoming more complex due to behavioral issues and in some cases intensive medical needs. The mix of client needs also adds to management complexity because it is not always appropriate or desirable for some groups of clients to mix. For example, some individuals under criminal commitment may need a secure setting and are not appropriately housed with individuals with severe medical needs. Concerns of this nature have lead the department to request funding (through the long range building plan) to modify buildings on the campus to facilitate the varying needs to the current population. The legislature may wish to pursue further study of the issues related to the changes in institutional population including the need for a more correctional type model of service for individuals criminally committed. Additional discussion of issues related to the institution population at the Montana Developmental Center is included in the program narrative for the Disability Services Division.

#### *Medicare Modernization Act (MMA)*

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was signed into law in December 2003. The most significant change due to passage of the MMA is the addition of an outpatient prescription drug benefit (Part D) for Medicare beneficiaries, which is one of the most fundamental changes to Medicare in recent history. Despite state and federal implementation issues, outpatient drug assistance is a significant benefit for Medicare beneficiaries. To date, there are many undefined aspects of the MMA, including the underlying data needed to calculate the fiscal effects.

The Part D benefit will be implemented January 1, 2006, so MMA requirements for state administrative duties, payments for retiree coverage, and cost sharing will be effective for three quarters of the 2007 biennium. The 2005 Legislature will deal with several impacts of the MMA that are common to all states. At this point, it is not possible to tell whether Montana will experience a net gain or loss in general fund costs due to offsetting aspects of the MMA, and it is not evident how fiscal and policy issues associated with the MMA will be addressed in the executive budget request or legislative package.

#### Impacts to States

The major state fiscal and public policy issues are:

- General fund savings due to federal assumption of prescription costs for some Medicare eligible persons currently eligible for and receiving Medicaid or Mental Health Services Plan (MHSP) prescription drug benefits
- General fund cost of state payments to the federal government for the Medicaid drug cost savings (the "clawback")
- Increased Medicaid costs due to new enrollees discovered during Part D outreach (the "wood work effect")
- General fund costs if the state opts to provide a "wrap around" benefit for potential or known Medicare prescription coverage gaps
- Administrative and workload impacts to provide low-income eligibility determination, beneficiary education, grievance resolution, and coordination with the Social Security Administration
- Potential for federal reimbursement of 28 percent of allowable costs for state health plan insurance coverage for drugs for Medicare eligible employees and retirees



### Cost Savings

The MMA expanded Medicare to provide an outpatient drug benefit to Medicare beneficiaries – including those who are also eligible for Medicaid prescription drug coverage (full benefit dual eligibles). Effective January 1, 2006, the act also discontinues federal financial participation for Medicaid outpatient drug costs for full benefit dual eligible Medicare beneficiaries. The exception to that prohibition occurs when state Medicaid plans cover drugs that are excluded for reimbursement by Medicare Part D (e.g. over the counter drugs that are equivalent substitutes for prescribed drugs).

The Montana Medicaid program includes coverage for outpatient prescription drugs, which is an optional Medicaid service. Total prescription costs for the Medicaid program are estimated to be about \$76 million in FY 2004. About 50 to 52 percent of prescription drug costs paid by Montana are for full benefit dual eligibles (those covered by both Medicare and Medicaid). Too many unknowns exist to even “guesstimate” what the potential savings could be. However, those cost savings will be offset by general fund cost increases that also cannot be quantified at this point.

Some persons eligible for the state funded MHSP are also eligible for Medicare. An important component of MHSP is payment for prescription drugs to treat mental illness. If such drugs are covered under the Medicare drug plan that a Medicare-MHSP eligible recipient chooses, there could also be savings in MHSP.

### The Clawback

The MMA requires that states make payments to the federal government (a clawback) to offset Medicaid program cost savings and help cover the cost of Part D for full benefit dual eligibles. The clawback will be based on an average per person Medicaid drug cost for full benefit dual eligibles in calendar year 2003. The base year per person cost will be inflated forward by a national rate established by the federal Center for Medicare and Medicaid Services (CMS). The clawback payment will be based on the inflated per person cost multiplied by the number of full benefit dual eligibles enrolled in a state Medicaid program each month. States will pay 90 percent of the clawback amount beginning in 2006, with the percent declining to 75 percent over 10 years.

Some states have expressed concern that the clawback will be higher than their share of Medicaid costs for full benefit dual eligibles. The concern arises because some states' pharmacy costs have grown at slower rates than national pharmacy or health inflation rates and because pharmacy cost saving measures implemented after 2003 will not be reflected in clawback calculations.

The Montana Medicaid program is in the process of implementing a preferred drug list that is expected to yield cost savings that will not be included in the clawback. DPHHS is also in the initial stages of working with CMS to determine the number and cost of full benefit dual eligibles in 2003. The number of full benefit dual eligibles is estimated to be between 17,000 to 20,000 of a total of about 110,000 Medicaid eligibles in the base year. However, there is no per person cost data yet, so it is not possible to estimate a preliminary clawback amount at this time.

The MMA establishes a cost ceiling for Medicare (45 percent of the U.S. Treasury). If future Medicare expenses exceed that ceiling, the clawback payments for states could be increased.

#### **LFD ISSUE**

Amount of Montana Clawback – DPHHS has been working with federal representatives to determine base level calendar year 2003 per person Medicaid costs for prescription drugs for persons who were also eligible for Medicare. In mid November 2004, Montana was one of eight states still trying to resolve data issues to make such a determination. LFD staff has requested that DPHHS update legislators about provisions of the clawback. The executive budget does not include the effect of the clawback.

The legislature may wish to evaluate the estimate of Medicaid prescription drug costs with respect to the clawback amount, if enough data exists to estimate the clawback. The legislature could also consider restricting the Medicaid prescription drug appropriation if it believes that there will be savings in the Medicaid program because of Part D.

Wood Work Effect

Some states are worried about the “wood work” effect – where Medicare Part D outreach identifies persons eligible for but not enrolled in Medicaid and then who subsequently enroll in Medicaid. This phenomenon has been apparent in other outreach efforts for new low-income programs in that existing programs experience increased enrollment. The Congressional Budget Office estimates that the number of people eligible for the Medicare low-income benefit exceeds the number of dual eligibles in Medicaid today. It is difficult to project state Medicaid cost changes due to Part D outreach.

**LFD  
ISSUE**

Medicaid Eligibility Increases – The executive budget does not include potential Medicaid cost increases due to eligibility increases from outreach for Part D benefits. Historically, outreach for a particular program has resulted in increased costs when persons learn they may be eligible for other social programs as well. For instance, about 30 percent of the children screened for CHIP program eligibility during CHIP outreach were referred to Medicaid.

The legislature could request the DPHHS provide an estimate of Medicaid eligibility increases associated with Part D outreach. The legislature, if it approves any appropriation authority for increases due to Part D outreach, could condition the appropriation such that it is spent only if eligibility for the dual eligible population increases a certain percent.

*Wrap Around Programs*

Some states have implemented state funded programs to pay for pharmacy costs not included in the Part D benefit for low-income beneficiaries, and for the “doughnut hole”, where there is no Part D assistance for pharmacy costs between \$2,250 and \$5,100 for beneficiaries with incomes above 150 percent of the federal poverty level. Wrap around programs must be supported entirely from state funds. The MMA eliminates the option for private sponsorship of prescription Medigap policies that could cover expenses not paid by Part D, (Joy Wilson, National Conference of State Legislatures, September 29, 2004), which may increase pressure for states to provide such coverage.

Medicare beneficiaries will choose among several different Medicare drug plans. At a minimum, each plan must include two drugs in each therapeutic class. If Medicare beneficiaries are unable to find one plan that would cover all medications that they are currently taking, they could be responsible for the cost of the drug(s) not covered or would need to switch to the covered drug. However, there are questions as to whether an appeal process would allow persons to access non covered drugs.

The legislature may see some requests for wrap around programs, including potentially one funded from the new \$1 tax on each pack of cigarettes. For instance, if Medicare eligible MHSP beneficiaries would be unable to obtain needed psychotropic medications through the Part D benefit and they were unable to obtain effective medications, their illness could worsen. The fiscal issue in this scenario is that without appropriate medications, persons may decompensate and be committed to the Montana State Hospital potentially at a greater cost to the state than the cost of appropriate medications.

*State Workload Issues*

There are several managerial and administrative tasks that states must perform in order to meet MMA mandates. States must:

- Perform eligibility for Part D low-income subsidies and/or provide assistance to the federal Social Security Administration; eligibility determination must evaluate an applicant’s income and resources
- Participate in a nation wide point-of-sale coordination of benefits between Medicare, Medicaid, and all private insurance payors to establish individual beneficiary co-payments and deductibles and to determine true out of pocket costs for Part D benefits
- Periodically notify the federal Centers for Medicaid and Medicare Services (CMS) of the income level of low-income beneficiaries and when the beneficiaries move into an institution
- Assist CMS in the determination of the base year costs for the clawback
- Provide information and assistance to Medicare beneficiaries in the event of complaints or grievances

While draft rules have been issued by CMS, the Social Security Administration has not yet issued final rules. Many of the requirements related to administrative tasks that states must perform are not yet clear. For instance, if the state must determine eligibility for low income beneficiaries, it is not known whether the state would accept a paper application and forward it to the Social Security Administration, or whether the state would be required to enter eligibility information in an automated system and make the determination. Even if states will not be required to perform eligibility, the MMA requires that states must be able to process Part D low-income eligibility as a condition of participating in the Medicaid program.

DPHHS is in the process of developing an eligibility system that will have some capabilities related to the MMA. It seems logical to assume that the eligibility determination process must be fully functional in advance of November 2005.

#### Federal Reimbursement for State Employee Health Plan Costs

Under the MMA states can be eligible for payments from the federal government if state employee health plans maintain prescription drug coverage for retired employees (payment of 28 percent of costs for a qualified plan). State plan coverage must be actuarially equivalent to or better than Part D coverage and the reimbursable costs paid per retiree must be at least \$250, but not greater than \$5,000 per year.

The State of Montana public employee insurance program appears to meet the criteria for reimbursement in draft rules, notwithstanding completion of an actuarial analysis. The amount of payment will depend on whether retirees opt to maintain state health insurance coverage or opt for a Medicare plan. Once a retiree opts for Medicare prescription drug coverage, he may not re-enter the state plan.

#### **LFD COMMENT**

Impacts of MMA – Legislative staff will coordinate among appropriation subcommittees and help track issues related to the MMA as the legislature considers appropriations and programmatic issues. However, many aspects of the MMA may not be defined in time for the legislature to take specific actions. Some policy decisions may need to be crafted as contingencies.

#### *Systems of Care*

In the last several biennia, the legislature has directed agencies with responsibilities for serving high-risk children to work cooperatively in serving those children who need services from more than one state agency. Sections 52-2-301 through 304, MCA declare that it is the policy of Montana to:

- Provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multi-agency service needs, to the extent that funds are available
- Serve high-risk children with multi-agency service needs either in their homes or in the least restrictive and most appropriate setting to preserve the unity and welfare of the family and use out-of-state providers as a last resort
- Provide integrated services to high-risk children with multi-agency service needs and to contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements
- Increase the capacity of communities to serve high-risk children with multi-agency service needs
- Prioritize available resources for meeting the essential needs of high-risk children with multi-agency service needs

#### DPHHS Actions to Implement Policy

Over the last four years, DPHHS has initiated working groups to implement a system of care for high-risk children with multi-agency service needs. The effort has progressed to the point that two pilot programs are established, and several more pilot programs are planned. In addition, DPHHS has received one of a limited number of competitive, nationwide five-year grants to assist in the development and implementation of a system of care.

A systems of care planning committee, as established in 52-2-303, MCA, was expanded in the summer of 2004 and includes representatives from the Department of Corrections; the Board of Crime Control; the Superintendent of Public Instruction; DPHHS representatives from children's mental health, developmental disabilities, child protective services, and chemical dependency programs; as well as providers, interest groups and family members. The group has met several times and worked on:

- Defining the role of the Systems of Care (SOCs) committee
- Defining the role, responsibilities, and structure of a Kids Management Authority (KMA – local representatives of state agencies and family members of children needing services)
- Training for expansion of KMAs
- Developing outcomes and measurements for those outcomes

### Basic Vision of the System of Care

The SOCs committee and pilot KMAs have provided definition to the system of care concept, yet much of the system is evolving. This summary explanation of the children's system of care is taken largely from a draft concept paper being written and approved by the SOCs committee ("An Introduction to Kids Management Authorities – KMAs", draft on November 12, 2004).

### How the System Will Work

The most integral, fundamental component of the system is development of a local KMA. The SOCs committee provides state leadership and coordination, but without development of effective KMAs at the local level, there would be no system of care.

### Kids Management Authorities (KMAs)

The KMA is the infrastructure that supports a comprehensive and statewide system of care. The KMA has two primary functions, development of a continuum of care within its respective community, and case planning and coordination for individual children who are seriously emotionally disturbed and their families. It also provides wrap-around services to children and their families within their community.

The SOCs committee, together with community KMAs, identifies training needs, service gaps, funding, and other barriers to service delivery. Together, they implement responses to identified needs.

### Funding

SOCs believes that funding for KMA operations:

- Must come from a variety of sources
- Should be flexible and not connected to any one category
- Should support best practice principles and serve the needs of youth and their families

The system of care document also states that: "Administrative functions related to KMAs will need assistance, including financial support. The DPHHS Health Resources Division's Children's Mental Health Bureau is committed to identifying funding to assist local KMAs."

### The Target Population for KMAs Services

KMAs are geared primarily toward children with serious emotional disturbances (SED) who are at risk of, or currently residing in, out-of-home placement and who are typically served by many agencies. The primary population also includes children under the age of six. The multiple treatment needs of these children evolve and change over time. Each KMA has the discretion to serve a secondary population of youth based on its ability to do so.

### KMA Community Design Team Membership

The KMA Community Team is a multi-agency community organization comprised of:

- Parents
- Youth
- State agencies serving children, including the DPHHS programs (Child and Family Services, Developmental Disabilities, and Health Resources), as well as the Department of Corrections and Youth Court
- Other programs that serve Montana's youth, including First Health (a contractor for DPHHS that provides quality assurance and prior authorization for high cost services)
- Tribal representatives
- Providers
- Advocates

KMA Community Team representatives will have the authority to make decisions about and allocate money for services to youth and their families. When the KMA is serving a tribal community, tribal representatives must have the opportunity to participate as full members in the KMA.

Because KMAs are local organizations, tribal communities may wish to develop them respective to their communities as an option to joining off-reservation KMAs. To ensure coordination with mental health regional planning entities (Service Area Authority), a representative of the regional authority must have the opportunity to participate as a full member in the KMA. The KMA may add representatives of other community organizations and leaders as appropriate.

#### Components of Executive Budget Request Related to Systems of Care

The executive budget includes several new proposals related to or that could support implementation of a children's system of care. All requests are included in the Health Resources Division budget. Each request, decision package number, and a short description are:

- DP 42 – Children's Mental Health Bureau
  - 5.00 new FTE
  - Net cost savings to general fund due to anticipated benefit cost reductions
  - Executive anticipates cost savings due to FTE ability to help identify local services and more quickly link services and children
- DP 146 – Children's Mental Health Bureau – SAMHSA Grant
  - 7.00 net FTE
  - \$3 million in federal grant funds over the biennium to help implement system of care
- DP 150 – Restore Children's Therapeutic Services
  - Reinstates expanded mental health benefits for CHIP eligible children with a serious emotional disturbance who require mental health services in excess of regular CHIP plan benefits
  - Estimated to serve 280 children
  - Request for \$1.4 million in federal CHIP matching funds, but no state matching funds
  - Services were originally eliminated in August 2002 to mitigate anticipated general fund cost overruns
- DP 189 – Waiver of Deeming
  - Waiver of federal Medicaid regulations to disregard parental income and assets to determine Medicaid eligibility for a child with a serious emotional disturbance
  - Part of Medicaid redesign recommendations
  - Request for \$100,000 state special revenue from co-payments based on family ability to pay
  - Requires legislation – LC 0293

#### **LFD ISSUE**

Issues Related to Children's System of Care – There are several issues that the legislature may wish to review with respect to the children's system of care.

#### Funding Flexibility

Over the years integration and coordination of children's services has been frustrating. While many studies and best practice models of care emphasize funding flexibility to provide unique and individualized services, such funding flexibility is difficult to develop and maintain. Obviously general fund is very flexible and doesn't have the strings that come with federal funding sources. However, the budget request doesn't include additional general fund for children's system of care services.

The legislature may wish to ask DPHHS staff how funding flexibility would be achieved and what funding sources, other than Medicaid or CHIP mental health funding, would be tapped? The legislature may also wish to ask DPHHS and other agency staff how ongoing service needs would be funded if the system plans to divert funds from current level services.

**LFD  
ISSUE  
CONT.**Medicaid Waiver

The children's mental health function will have some added flexibility if the waivers of deeming and homes and community based services are approved. However, the legislature may wish to request that DPHHS staff explain with more detail than is available in the bill draft request:

- What waiver services would be provided
- How would children be selected for the waiver
- How much would be spent on the waiver
- How many children would be served
- How will funds be allocated among KMAs

How Would Local KMAs Interface with Service Area Authorities?

The legislature adopted the executive plan to move to regional mental health managed care, which was proposed during the 2001 session. Since that time, the legislature made statutory changes to establish Service Area Authorities (SAAs), the planned regional managed care authorities, in statute. Since that time, Authorities have slowly evolved, with the Central Service Area Authority advancing most quickly.

DPHHS has changed the focus of SAAs from entities that would assume financial risk in delivering services, to more of a planning and advisory body to DPHHS. Statute does not specify that SAAs are to assist in planning only for adult mental health services and the Central SAA includes representatives for both adult and children's mental health services.

DPHHS has requested a bill (SB 42) to clarify that KMAs are the primary entity for planning and developing children's mental health services. However, the bill draft is not clear with regard to how the relationship between SAAs and KMAs will work. The legislature may wish to ask DPHHS staff to clarify the relationship and how it envisions entities will be integrated or work together.

Would the Legislature Like to Maintain Oversight During the Interim?

The legislature could monitor system implementation through the 2007 biennium if it considers the issues important and if it would like to discuss and potentially influence interim work. The legislature has several interim committees that could perform such duties. The Interim Committee on Children, Families, Public Health and Human Services focuses on DPHHS activities, while the Legislative Finance Committee has a broader scope that can consider all agency work related to fiscal and programmatic policies. The legislature could request that either or both of these committees provide oversight of system development, either through a resolution or through an amendment to the statutory duties of the committee.

Other System of Care Activities

Another division within DPHHS – Public Health and Safety – is also requesting federal authority to design a plan for an Early Childhood Comprehensive System (Early Childhood System) in Montana (DP 160). The core group responsible for the initial planning for this grant also will be co-chaired by the chief of the Family and Community Bureau and the chief of the Early Childhood Services Bureau and includes members from the Head Start/State Collaboration office, the Healthy Start Association, and the Children's Mental Health Bureau. Tasks to be completed with this funding are:

- Develop a leadership partnership to develop, implement, and monitor a plan for an Early Childhood System in Montana
- Establish contractual arrangements needed to enable the work of the task force and contributors to the plan development, i.e. facilitators, data manager, evaluator
- Establish vision, mission, and guiding principles of the Early Childhood System in Montana
- Develop a plan for an Early Childhood System in Montana that addresses five targets
  - Access to health insurance and a medical home
  - Mental health and social-emotional development
  - Early care and education/child care

- Parent education
- Family support
- Solicit input regarding desired outcomes for Early Childhood System
- Develop a final Early Childhood System Plan
- Develop implementation plan, including action steps
- Determine resources needed to support the implementation plan
- Develop request for the next application phase, either planning or implementation

Although the mental health and social-emotional development is only one of the five target areas of the Early Childhood System and the Early Childhood System plan will be geared toward all children and more providers and families than the mental health children's system of care, it is important that the two efforts are coordinated and avoid duplication. Including the Children's Mental Health Bureau Chief on the planning committee is certainly a step in that direction. However, the legislature may wish to review what other specific steps might be taken.

#### LFD ISSUE

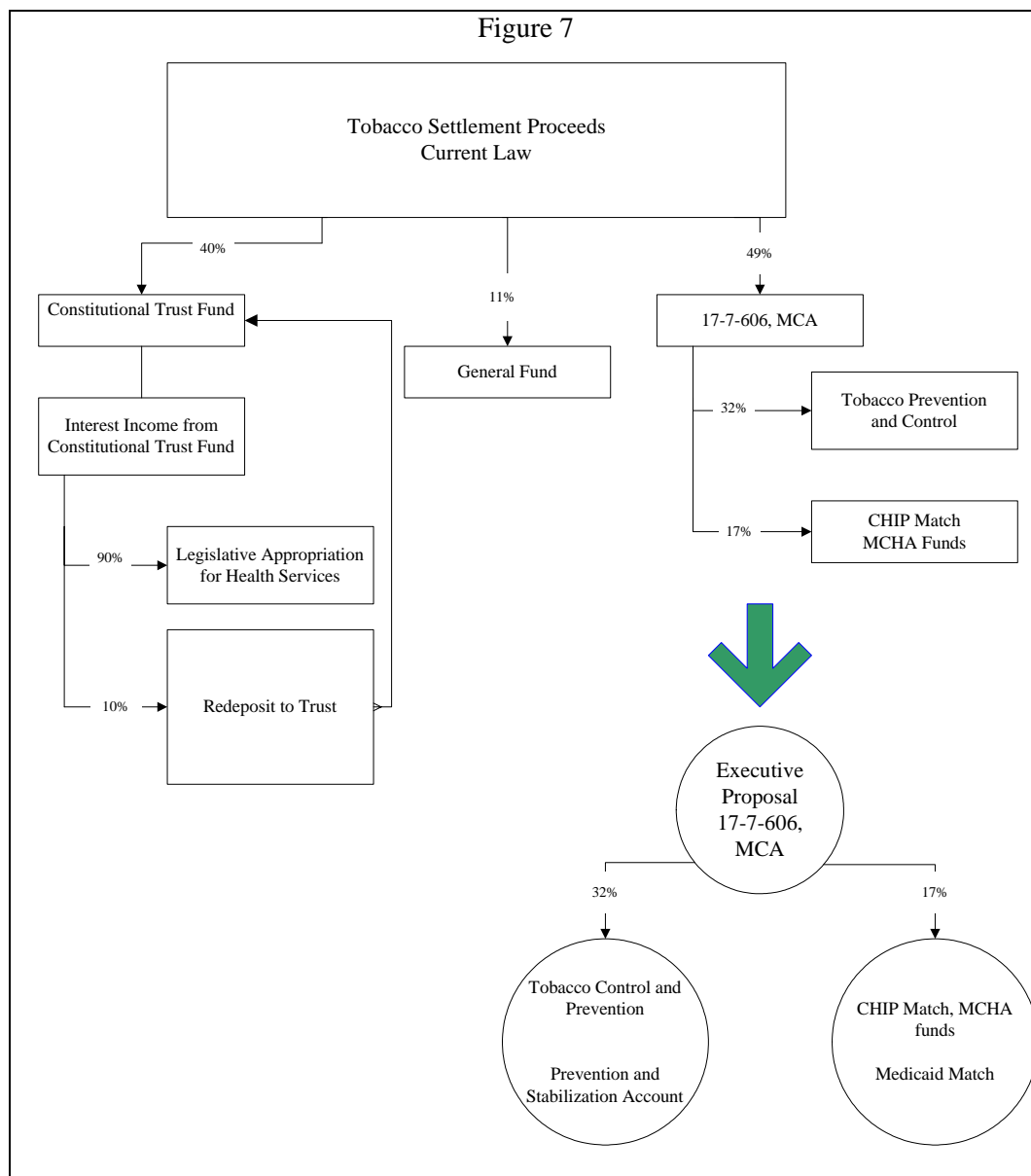
DPHHS Integration of the Early Childhood Comprehensive System and Children's System of Care – DPHHS has received two federal grants from different federal funding sources that allow the department to plan for children's systems of care in collaboration and cooperation with a large number of stakeholders. In many instances these grants will rely on input from the same stakeholders and have some of the same goals. LFD staff has requested that DPHHS explain to the Health and Human Services Joint Appropriation Subcommittee how the two systems will be integrated.

#### *Tobacco Settlement Funds*

Montana receives funds from a settlement agreement of a lawsuit against cigarette manufacturers. The tobacco settlement funds have been allocated by voter initiative twice:

- Once in November 2000 to establish a constitutional trust fund that receives 40 percent of settlement proceeds
  - 90 percent of the trust interest income can be appropriated for health care uses
  - 10 percent of the interest is deposited into the trust
  - The corpus of the trust can be used if approved by a super majority vote of the legislature
- Once in November 2002 to establish two state special revenue accounts in statute (17-6-606, MCA) that receive
  - 32 percent of tobacco settlement proceeds for tobacco prevention and control
  - 17 percent of tobacco settlement proceeds for CHIP match and the Montana Comprehensive Health Association (MCHA) to provide insurance for persons who cannot obtain health insurance or to provide premium assistance for low-income persons to maintain their health insurance

Figure 7 shows a diagram of the allocation of the tobacco settlement funds that will be in effect July 1, 2005. The executive budget request that depends on permanent reallocation of tobacco settlement funds are listed in the bottom part of the diagram.





### *Temporary Use of Tobacco Settlement Funds – SB 485*

The 2003 Legislature enacted temporary amendments to 17-6-606, MCA through SB 485 to allow for the 2005 biennium only:

- Appropriation of \$3 million of CHIP/MCHA funds for state Medicaid match
- Diversion of \$12 million of the tobacco settlement proceeds allocated for tobacco prevention and control into the prevention and stabilization account to continue to fund a number of programs slated for elimination or reduction in the 2005 biennium executive budget proposal including
  - Mental Health Services Plan (MHSP) drugs - \$6.5 million
  - Child care matching funds - \$2 million
  - Montana Initiative for the Abatement of Mortality in Infants (MIAMI) - \$1.1 million
  - Child support enforcement matching funds - \$1.3 million
  - Independent living and extended employment services - \$1 million
  - Various Medicaid state matching funds for hospice, home health therapies, and mental health services - \$1.2 million
  - Poison control, AIDS funding - \$0.2 million

### Executive Budget Continues Diversion

The executive budget continues the same diversion of tobacco settlement funds for most of the same programs. However, the amount allocated to CHIP from tobacco settlement funds falls from \$1.2 million annually to about \$880,000, because the executive budget shifts a portion of the match to the Mental Health Services Plan (MHSP).

### Implication for Medicaid Redesign

The executive budget relies on reallocation of tobacco settlement revenue to implement a cornerstone of its Medicaid redesign proposal. Tobacco settlement revenue is requested for continuation of the MHSP prescription drug program for the HIFA (Health Insurance Flexibility and Accountability) waiver. The MHSP funds are used as state matching funds to draw down additional federal Medicaid funds and to expand health insurance coverage for low-income persons.

Figure 8 Tobacco Settlement Revenue 2005 and 2007 Biennia				
Estimated Total Revenue/ Allocation	Actual FY 2004	Estimated FY 2005	Estimated FY 2006	Estimated FY 2007
Total Settlement Revenue	\$ 26,672,072	\$ 26,102,000	\$ 21,084,000	\$ 20,988,000
40% to Trust*	10,668,829	10,440,800	8,433,600	8,395,200
32 % to Prevention/ Control State Special Rev.	8,535,063	8,352,640	6,746,880	6,716,160
17% to CHIP/MT. Comp. Association State Special Rev.	4,534,252	4,437,340	3,584,280	3,567,960
Balance to General Fund	2,933,928	2,871,220	2,319,240	2,308,680

### Tobacco Settlement Revenues Projected to Decline

The Interim Revenue and Transportation Oversight Committee adopted estimates for tobacco settlement revenue in November 2004 that are anticipated to decline from FY 2004 receipts of nearly \$27 million to about \$21 million annually during the 2007 biennium (See Figure 8). The reduction was adopted because of a condition in the Master Settlement Agreement that allows for settlement payments to be adjusted if the settling parties lose market share due to the conditions of the settlement, such as advertising the hazards of smoking and foregoing certain types of advertising to sell cigarettes.

The reduction in tobacco settlement funds ripples through the accounts that receive settlement revenue. Trust deposits decline from nearly \$11 million in FY 2004 to \$8 million in the 2007 biennium. Similar reductions are shown for amounts deposited for prevention and control activities as well as CHIP match and Montana Comprehensive Health Association (MCHA) funding.

### Interest Income from the Trust Fund

Figure 9 shows the fund balance for the tobacco settlement trust interest income and executive budget request for the 2007 biennium. Revenues are those adopted by the Revenue and Transportation Oversight Committee. As in past biennia, all appropriation requests support a portion of the state Medicaid match for various services.

**Figure 9**  
Tobacco Settlement Constitutional Trust Fund - Income and Budget Request

Income/Expenditures	Actual FY 2004	Appropriation FY 2005	Executive Request FY 2006	Executive Request FY 2007
Beginning Balance	\$2	\$2	\$0	\$51,100
Income*	\$2,402,846	\$2,810,700	\$3,338,100	\$3,807,000
Expenditures for Medicaid Match				
Hospital Services	\$484,406	\$700,100	\$1,368,560	\$1,859,560
Acute Services	953,450	1,377,998	953,450	953,450
Children's Mental Health	233,552	337,547	233,552	233,552
Nursing Homes	703,779	703,779	703,779	703,779
Mental Health	27,659	27,659	27,659	27,659
Total Expenditures	<u>\$2,402,846</u>	<u>\$3,147,083</u>	<u>\$3,287,000</u>	<u>\$3,778,000</u>
Cost (Over) Under Revenue**	<u>\$2</u>	<u>(\$336,381)</u>	<u>\$51,100</u>	<u>\$80,100</u>

\*Income is the amount adopted in revenue projections approved the Revenue and Transportation Oversight Committee.  
 \*\*The negative balance doesn't carry forward into FY 2006, because DPHHS will not be able to fully expend the appropriations due to inadequate cash in the account.

**LFD  
ISSUE**

Income from the Tobacco Settlement Trust Fund – The legislature may have an additional \$80,100 in interest income from the tobacco settlement trust fund to allocate over the 2007 biennium. As shown in Figure 9, while the appropriations from the income exceed anticipated revenues in FY 2005, the amount requested in the executive budget is less than the interest income projections for the 2007 biennium.

DPHHS cannot spend the full amount of the FY 2005 appropriations since there will not be adequate cash in the account. The legislature may wish to ask DPHHS how it is reallocating expenditures to cover the shortfall in tobacco settlement funds.

### CHIP and MCHA Account

Figure 10 shows the projected revenues and executive budget request for the tobacco settlement funds (17 percent) allocated to CHIP and MCHA. The executive proposal reduces the amount spent for CHIP match from \$2.7 million in FY 2004 to about \$0.9 million each year of the biennium. The amount budgeted for MCHA remains constant.

**Figure 10**  
Tobacco Settlement Revenue Allocated to  
CHIP and MT Comprehensive Health Association (MCHA)

Estimated Revenue/ Executive Request	Actual FY 2004	Approp. FY 2005	Executive Request FY 2006	Executive Request FY 2007
Beginning Balance	\$0	(\$12,645)	\$0	(\$83,011)
Revenue	\$4,534,252	\$4,437,340	\$3,584,280	\$3,567,960
Expenditures				
CHIP Match	\$2,656,626	\$2,810,311	\$880,201	\$998,180
Medicaid Match*	1,285,901	1,443,189	1,323,210	1,346,732
MT Comp. Health	573,215	659,600	573,215	659,600
Mental Health Svcs	0	0	890,665	845,275
Other DPHHS Cost	<u>31,161</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total Expenditures	<u>\$4,546,903</u>	<u>\$4,913,100</u>	<u>\$3,667,291</u>	<u>\$3,849,787</u>
Adjustments	<u>\$6</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>
Ending Balance**	<u>(\$12,645)</u>	<u>(\$488,405)</u>	<u>(\$83,011)</u>	<u>(\$364,838)</u>

\*17-6-606, MCA would need to be amended to continue to allow Medicaid costs to be paid from the tobacco settlement revenues allocated to CHIP and MCHA.  
 \*\*The negative ending balance in FY 2005 will not be carried forward into FY 2006 since DPHHS cannot fully expend appropriations without adequate cash in the fund.

The executive budget requests continuation of the one-time appropriation during the 2005 biennium for Medicaid matching funds from the CHIP/MCHA account, slightly increasing the annual 2007 biennium appropriation above the FY 2004 expenditure. The Office of Budget and Program Planning notified LFD staff that the allocation to the Mental Health Services Plan (MHSP) is an error and should be allocated to the Medicaid program, but did not specify which Medicaid program.

### LFD ISSUE

CHIP/MCHA Tobacco Settlement Allotment - As shown in Figure 10, the amount that the executive has requested from the CHIP/MCHA allotment of tobacco settlement funds is about \$0.4 million in excess of projected revenues. If the legislature approves the executive request, it may wish to alter appropriation levels to be within anticipated funding and it would need to amend 17-6-606, MCA to use the funds for Medicaid match.

If the legislature does not approve the executive proposal, it would need to either find an alternative source of funds to support Medicaid and CHIP match or reduce services.

The amount appropriated in FY 2005 from the CHIP/MCHA allotment is estimated to exceed available revenues by nearly \$0.5 million. The legislature may wish to know which appropriation DPHHS will reduce since revenues are not expected to be sufficient.

### *Tobacco Control and Prevention Account*

Figure 11 shows the fund balance for the portion (32 percent) of tobacco settlement proceeds allocated to tobacco prevention and control. The fund balance at the end of the biennium is about \$8 million in excess of requested expenditures for tobacco prevention and control.

Figure 11  
Tobacco Settlement Revenue Allocated to  
Tobacco Prevention and Control - Present Law

Estimated Revenue/ Present Law	Actual FY 2004	Approp. FY 2005	Present Law	
			FY 2006	FY 2007
Beginning Balance	\$0	\$169,649	\$0	\$4,232,235
Revenue	\$8,535,063	\$8,352,640	\$6,746,880	\$6,716,160
Expenditures*				
Prevention/Control	\$2,514,645	\$3,200,000	\$2,514,645	\$2,514,645
Transfer to Prevention and Stabilization Account	5,831,360	6,057,600	0	0
Other DPHHS Cost	19,415	0	0	0
Total Expenditures	\$8,365,420	\$9,257,600	\$2,514,645	\$2,514,645
Adjustments	\$6	\$0	\$0	\$0
End Balance - Pres. Law	\$169,649	(\$735,311)	\$4,232,235	\$8,433,750

\*The 2003 Legislature reallocated \$12 million of tobacco settlement funds from tobacco and control to the prevention and stabilization account during the 2005 biennium. Statute needs to be changed if the reallocation is to continue.

The executive budget continues the amount spent on tobacco prevention and control in FY 2004. The budget request adds about \$0.2 million general fund annually.

### *Prevention and Stabilization Account*

The 2003 Legislature created the prevention and stabilization account (53-6-111, MCA). Revenue from federal Medicaid reimbursement for a portion of bed utilization taxes paid by state institutions is deposited into the account. During the 2005 biennium, the legislature authorized a one-time transfer of \$12 million from tobacco settlement proceeds allocated to tobacco prevention and control to the account and funded a variety of programs from the appropriations.

Figure 12 shows the anticipated account balance and the executive budget proposal, which requests continuation of the 2005 biennium one-time appropriations. Estimated revenue to

the prevention and stabilization account is inadequate to support the executive proposal, with appropriation requests totaling \$9 million above revenues.

The executive budget proposes to transfer a portion of tobacco settlement proceeds to the account. The estimated amount available to transfer (about \$13 million over the biennium) would not be sufficient to cover appropriation requests. Figure 11 shows the calculation of revenue available to transfer.

**Figure 12**  
**Prevention and Stabilization Account Revenues and Costs**

Revenue/Expenditure	FY 2004 Actuals	FY 2005 Appropriation	Executive Budget	
			FY 2006	FY 2007
Beginning Fund Balance	\$318,265	\$1,006,673	\$0	(\$5,393,869)
<b>Revenues</b>				
Tobacco Settlement Fees*	\$5,831,360	\$6,057,600	\$0	\$0
Utilization Fees	690,782	615,000	615,000	615,000
Subtotal Revenue	\$6,522,142	\$6,672,600	\$615,000	\$615,000
Total Revenues	\$6,840,407	\$7,679,273	\$615,000	(\$4,778,869)
<b>Expenditures</b>				
Mental Health Servs	\$2,611,837	\$3,689,734	\$2,359,335	\$2,404,725
CSED Administration	750,004	513,678	1,263,678	0
MIAMI**	522,395	516,828	550,000	550,000
Medicaid/Clinical Services	0	186,321	601,571	0
Child Care Match	557,000	1,443,000	350,711	349,352
Extended Employment	246,326	0	270,639	270,639
Independent Living	228,766	523,718	228,766	228,766
Home Based Medicaid	204,000	204,000	204,000	204,000
Mental Health Medicaid	198,429	198,429	99,215	99,215
AIDS Treatment**	60,778	84,000	42,000	42,000
Poison Control Line**	38,954	38,954	38,954	38,954
Children's Mental Health	415,250	0	0	0
Director's Office	0	653,731	0	0
Total Expenditures	\$5,833,739	\$8,052,393	\$6,008,869	\$4,187,651
Adjustments	\$5	\$0	\$0	\$0
Ending Fund Balance	\$1,006,673	(\$373,120)	(\$5,393,869)	(\$8,966,520)
Executive Proposal to Transfer Tobacco Settlement			\$4,232,235	\$8,433,750
Funds from Tobacco Control and Prevention				
Revised Executive Budget Balance			(\$1,161,634)	(\$532,770)

\*SB 485 (17-7-606(4), MCA) diverted a portion of tobacco settlement revenue from tobacco control and prevention to fund human services programs during the 2005 biennium. The diversion terminates June 30, 2005.

\*\*Some of the executive requests are biennial appropriations.

**LFD  
ISSUE**

Prevention and stabilization account – The legislature would need to amend statute to divert tobacco settlement funds from tobacco control and prevention to the prevention and stabilization account. If the legislature approves the executive request, it may wish to modify appropriation levels so that expenditures remain within revenue levels.

If the legislature does not approve the executive request to continue the diversion of tobacco settlement revenue, it may wish to:

- Appropriate a different source or amount of funds to support some or all of the request
- Make service reductions
  - If the legislature does not appropriate funds to continue the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) it would need to remove the requirement from statute for the program (50-19-300 through 304, MCA)

The appropriation requested for the Mental Health Services Plan (MHSP) is the main source of state Medicaid matching funds for the center piece of the Medicaid redesign proposal – the HIFA (Health Insurance Flexibility and Accountability) Waiver. If the legislature wishes to direct DPHHS to pursue the HIFA waiver, but does not approve the appropriation in Figure 12, it would need to:

- Appropriate a different funding source or
- Change the parameters and program expansions included in the HIFA conceptual design

FY 2005 appropriation requests from the prevention and stabilization account are in excess of projected revenues. The legislature may wish to ask DPHHS how it will change expenditures to live within the cash available and what impact those changes will have.

It should be noted that an amendment to statute (17-7-606, MCA) would be required to implement the executive proposal.

#### *I-149 – Cigarette Tax Increase*

The voters passed initiative I-149 in the November 2004 election. The initiative increases taxes on cigarettes by \$1 per pack and creates a health and Medicaid state special revenue account to be administered by DPHHS (53-6-12-1, MCA). Funds in the account shall be used only to provide funding for:

- State funds necessary to maximize enrollment of eligible children in CHIP and to provide outreach to the eligible children
  - The increased revenue is intended to increase enrollment rates for eligible children in the program and not to be used to support existing levels of enrollment based upon appropriations for the biennium ending June 30, 2005
- A new need-based prescription drug program established by the legislature for children, seniors, chronically ill, and disabled persons that does not supplant similar services provided under any existing program
- Increased Medicaid services and Medicaid provider rates
  - The increased revenue is intended to increase Medicaid services and Medicaid provider rates and not to supplant the general fund in the trended traditional level of appropriation for Medicaid services and Medicaid provider rates
- An offset to loss of revenue to the general fund as a result of new tax credits or to fund new programs to assist small businesses with the costs of providing health insurance benefits to employees, if these tax credits or programs are established by the legislature after the effective date of this section
  - Until the programs or credits are established, the funding shall be used exclusively for the above noted purposes

A group of interest parties has been meeting, including representatives of the Governor-Elect, the State Auditor, the American Cancer Society, DPHHS, AARP (American Association of Retired Persons), Montana Nurses' Association, Blue Cross Blue Shield, hospitals, and nursing homes as well as low-income advocates. The goal of this group is to develop and present a plan to implement I-149 to the 2005 Legislature.

#### **LFD COMMENT**

LFD staff has requested that this plan be presented to the Health and Human Services Joint Appropriation Subcommittee. Depending on elements of the plan and legislative action, it may be necessary to pass legislation to implement the proposal. For instance, if a plan to provide a prescription drug benefit is proposed, the legislature may wish to establish program guidelines in statute.

#### *Federal Fiscal Relief*

DPHHS received just over \$4.0 million of federal fiscal relief funds from the 2005 biennium. Federal fiscal relief funds were provided to the department to support Meals on Wheels (\$0.5 million), low-income energy assistance (\$2.0 million), and a reduction of vacancy savings required at the state institutions operated by the department (\$1.5 million).

In addition to the federal fiscal relief funds allocated to the department, a portion of the general fund savings available due to the temporary reduction in the state Medicaid match rate was expended by the department. About \$3 million of general fund savings due to the lower state match rate was used to support CHIP (\$0.6 million), child support enforcement services (\$1.0 million), and TANF maintenance of effort (\$1.3 million). This funding supported:

- Expansion of the CHIP program to 10,900 children annually
- Ongoing funding shortfalls within the Child Support Enforcement Division
- Expenditure of general fund so that the TANF maintenance of effort requirement was met on a state fiscal year basis rather than just on a federal fiscal year basis. This funding increase was requested in the executive budget for the 2003 biennium and rejected by the legislature. The expenditure of these funds offset spending reductions ordered by the Governor during the summer of 2002 under the requirements of 17-7-140, MCA

*TANF Spending Changes*

On December 9, 2004 Governor Martz and DPHHS Director Gray announced a number of increases in Temporary Assistance for Needy Families (TANF) spending that would be effective January 1, 2005. These changes include:

- Increasing TANF cash assistance benefits an average of \$30 per month
- Using \$500,000 to provide “work support” benefits to those leaving the program due to employment

Additionally, the Governor and director announced that the TANF performance bonus Montana received for federal FY 2003 would be used to provide one-time funding for:

- Low income energy assistance, \$500,000
- Grants to after-school programs, \$375,000
- Training and office improvements for local public assistance offices and employment training contractors, \$500,000

These spending proposals and increases in TANF cash assistance benefit levels are not included in the executive budget for the 2007 biennium, nor has the financial impact of these changes been estimated or analyzed by legislative staff. Further information on these spending changes will be presented to the 2005 Legislature.

**Agency Issues****Other Issues***Travis D. Settlement Agreement and Potential Cross System Impacts*

The Travis D. litigation was a class action lawsuit filed by the Montana Advocacy Program (MAP) in 1996 on behalf of individuals with developmental disabilities. The lawsuit sought to protect the civil rights of individuals with disabilities and the provision of appropriate community services for individuals with disabilities. The class of plaintiffs in this suit was individuals with developmental disabilities who are, have been, or will be residents of the Montana Developmental Center (MDC) or Eastern Montana Human Services Center (Eastmont) during a specified time period. The defendants in this litigation were the state of Montana, MDC, and various employees of the state.

On February 5, 2004 a court ordered settlement agreement of this litigation was signed. This settlement agreement contains a number of provisions specific to the DD system, which are discussed in more detail in the narrative for the Disability Services Division. In addition to the impact of the settlement agreement on the DD system, potential impacts on other disability systems are summarized below.

*Larger Implications of the Travis D. Settlement*

Legislative legal counsel answered a number of legislative questions regarding the settlement agreement in the Travis D. litigation in a letter dated April 19, 2004. This letter may be obtained by contacting the legislative library. The legal analysis highlights some potential issues and impacts of the Travis D. litigation settlement agreement that may apply broadly to the all disability service systems administered by DPHHS. The potential impacts may be:

- Broader Medicaid eligibility criteria
- Mandate to provide certain optional Medicaid services
- Equal protection concerns

*Broader Medicaid Eligibility Criteria*

Section B.10.1.1 of the settlement agreement provides that the defendants will take all reasonable actions legally and administratively feasible to maximize federal funding for community DD programs through efforts to assist persons not currently eligible for Medicaid to become eligible for Medicaid. It would seem that changing Medicaid eligibility criteria so that more developmentally disabled individuals qualify for the program could constitute a reasonable and administratively feasible action to achieve this goal. Any change to expand eligibility and increase the number of developmentally disabled individuals eligible for all Medicaid covered services would be applicable to other disabled individuals.

Mandate To Provide Certain Optional Medicaid Services and Cost Shift

Section B.9.3.1 requires that DPHHS make mental health and dental care services available to the class of persons covered by the Travis D. settlement. These services are considered optional Medicaid services, meaning that federal rules allow a state to decide whether to offer such services as part of its Medicaid program. However, the settlement has made provision of those services mandatory for the covered class of persons. This part of the settlement removes an aspect of administrative flexibility in DPHHS budget management and shifts the cost of providing services from the DD system appropriation to other disability systems. For example, DPHHS eliminated payment for outpatient Medicaid mental health services for adults unless they have a serious and disabling mental illness. The settlement will reinstate such services for the covered class of persons. Since the cost of mental health services is funded in the Addictive and Mental Disorders Division, this aspect of the settlement agreement shifts costs to another service system.

Equal Protection Concerns

In the referenced correspondence, legislative legal counsel notes the Equal Protection Clause contained in section 1 of the 14<sup>th</sup> Amendment to the United States Constitution and the equal protection guarantee contained in Article II, section 4, of the Montana Constitution. These clauses “guarantee equality of treatment for similarly situated individuals” and are referenced regarding potential implications of the settlement agreement in provision of services both within the DD system and in provision of services in other disability service systems. Legislative legal counsel discusses the need for a rational basis establishing criteria for providing or denying services and comments that the rational basis for providing services to the group covered by the settlement agreement and denying those same services to developmentally disabled individuals who are not covered by the settlement agreement is difficult to discern. It also would seem that arguments based on equal protection provisions might apply in the provision of dental and mental health services, which the settlement agreement requires the department make available to class members through the Montana Medicaid program, and might also be extended to other institutional populations that desire community based services rather than institutional services. It is possible that such arguments might be used to influence the legislature to expand and/or equalize the provision of services within and among groups of individuals with varying disabilities or, on the other hand, to reduce services provided to certain classes of individuals.

**LFD  
ISSUE**

The legislature may wish to:

- Have legislative legal counsel review with the Health and Human Services Joint Appropriations Subcommittee questions and responses included in the referenced correspondence
- Direct the department to develop and implement administrative rules that prioritize provision of services based upon clinical criteria and financial status of the individual (and if a child, the child’s family resources) so that similarly situated individuals are treated the same
- Consider statutory changes to limit the amount, scope, or duration for services, or eligibility for services, including the potential use of income or asset criteria to determine eligibility
- Conduct an interim study of potential actions and statutory changes that might be desirable to address the implications of the settlement of this case, including both public policy and system financing issues, for presentation to the next legislature

*M.A.I.D.S. Lawsuit*

In September 2002, the Montana Association for Independent Disability Services, Inc. (MAIDS) and several individuals with developmental disabilities filed suit. Defendants in the MAIDS lawsuit include the Department of Public Health and Human Services and key department and state personnel. MAIDS is a non-profit organization comprised of entities providing community-based services to individuals with developmental disabilities. This suit alleges that the disparity in wages and benefits paid to employees of community based providers verses the wages and benefits paid to employees of state institutions has resulted in irreparable and unnecessary harm to the plaintiffs. The plaintiffs allege that several statutory and constitutional provisions have been violated and seek: 1) to have the wage and benefit disparity between employees of state run institutions and community providers eliminated; and 2) to have uniform Medicaid reimbursement rates established. The court is schedule to hear this lawsuit in August of 2005.

A finding in favor of the plaintiffs and requiring the state to reimburse contractors at a level that provides direct care wage rates that are comparable to state employees would likely have a financial impact on the DD system that would be measured in terms of millions of dollars. The potential for similarly situated employee groups of contractors to file similar legal actions exist. The probability and magnitude of such action is currently unknown. Furthermore, how such a finding might impact the definition of employee employer relationships and other aspects of labor relations and compensation has not been studied.

### Federal Poverty Level

Figure 13 shows the 2004 federal poverty level index by family size for various levels of poverty. This index is published each calendar year and updated in February or March. Generally the federal poverty level index increases each year between 2 and 5 percent.

Throughout the DPHHS budget analysis there are references to program financial eligibility based on an established level of poverty. The levels of poverty shown in Figure 13 reflect most of the financial eligibility levels for DPHHS programs. CHIP financial eligibility is currently 150 percent of the poverty level. Financial eligibility for some Medicaid programs for low-income children and pregnant women is established at 100 percent and 133 percent of the federal poverty level. MHSP financial eligibility is established at 150 percent of the poverty level. Chemical dependency services are provided to individuals with incomes below 200 percent of the federal poverty level. The eligibility and benefit level of TANF cash assistance is established at about 30 percent of the 2002 federal poverty level index. TANF cash assistance eligibility and benefit levels are no longer routinely increased as the federal poverty level index, rather they have remained constant based upon the 2002 federal poverty level index.

Figure 13 2004 Federal Poverty Index Levels of Poverty by Family Size						
Family Size	Percent of Federal Poverty Level					
	30%	100%	133%	150%	175%	200%
1	\$2,793	\$9,310	\$12,382	\$13,965	\$16,293	\$18,620
2	3,747	12,490	16,612	18,735	21,858	24,980
3	4,701	15,670	20,841	23,505	27,423	31,340
4	5,655	18,850	25,071	28,275	32,988	37,700
5	6,609	22,030	29,300	33,045	38,553	44,060
6	7,563	25,210	33,529	37,815	44,118	50,420
7	8,517	28,390	37,759	42,585	49,683	56,780
8	9,471	31,570	41,988	47,355	55,248	63,140
Each Additional Person	954	3,180	4,229	4,770	5,565	6,360

### New Proposals

The "New Proposal" table summarizes all new proposals requested by the executive. Descriptions and LFD discussion of each new proposal are included in the individual program narratives.

New Proposals										
Program	FTE	Fiscal 2006				Fiscal 2007				
		General Fund	State Special	Federal Special	Total Funds	FTE	General Fund	State Special	Federal Special	Total Funds
DP 2 - Continuation of PSA for Mental Health Services (Requires Legislation)										
33	0.00	0	3,250,000	0	3,250,000	0.00	0	3,250,000	0	3,250,000
DP 3 - Continuation of PSA for Independent Living (Requires Legislation)										
10	0.00	0	228,766	0	228,766	0.00	0	228,766	0	228,766
DP 4 - Continuation of PSA for Hospice and Home Therapy (Requires Legislation)										
22	0.00	0	204,000	0	204,000	0.00	0	204,000	0	204,000
DP 5 - Continuation of PSA for Child Care (Requires Legislation)										
02	0.00	315,342	350,711	0	666,053	0.00	232,885	349,352	0	582,237
DP 6 - Continuation of PSA for Child Support Enforcement (Requires Legislation)										
05	0.00	0	1,263,678	0	1,263,678	0.00	0	0	0	0
DP 7 - Continuation of PSA for MIAMI (Requires Legislation)										
07	0.00	0	1,100,000	0	1,100,000	0.00	0	0	0	0
DP 8 - Continuation of PSA for Adult Mental Health (Requires Legislation)										
33	0.00	99,214	99,215	0	198,429	0.00	99,214	99,215	0	198,429
DP 9 - Continuation of PSA for Medicaid (Requires Legislation)										
11	0.00	0	601,571	0	601,571	0.00	0	0	0	0
DP 10 - Continuation of PSA for Extended Employment (Requires Legislation)										
10	0.00	0	270,639	0	270,639	0.00	0	270,639	0	270,639
DP 11 - Continuation of PSA for AIDS Prevention (Requires Legislation)										
07	0.00	0	84,000	0	84,000	0.00	0	0	0	0
DP 12 - Continuation of PSA for Poison Control (Requires Legislation)										
07	0.00	0	77,908	0	77,908	0.00	0	0	0	0
DP 38 - Manage Medicaid Pharmacy Program										
11	1.00	(1,165,170)	0	(3,353,302)	(4,518,472)	1.00	(834,359)	0	(2,494,238)	(3,328,597)
DP 39 - Movement to Community Services										
10	(35.00)	(171,846)	0	1,604,871	1,433,025	(35.00)	(786,731)	0	1,508,243	721,512
DP 42 - Enhance Efficiency of Children's Mental Health Svc										



## Public Health &amp; Human Services

## SUMMARY

New Proposals											
Program	FTE	Fiscal 2006				Fiscal 2007					Total Funds
		General Fund	State Special	Federal Special	Total Funds	FTE	General Fund	State Special	Federal Special	Total Funds	
11	5.00	(55,958)	0	(418,384)	(474,342)	5.00	(54,354)	0	(395,714)	(450,068)	
DP 43 - Medicaid Cost Analysis											
11	2.00	(19,573)	0	(122,865)	(142,438)	2.00	(24,179)	0	(124,578)	(148,757)	
DP 44 - Medicaid Passport Services											
11	2.00	(13,425)	0	(14,426)	(27,851)	2.00	(13,520)	0	(14,559)	(28,079)	
DP 50 - MT Mental Health Nursing Care Center Bed Tax											
33	0.00	135,415	0	0	135,415	0.00	135,415	0	0	135,415	
DP 58 - Enhance Community Psychiatric Access											
33	0.00	66,987	0	161,715	228,702	0.00	68,428	0	160,274	228,702	
DP 68 - Restore Meals on Wheels Funding											
22	0.00	257,000	0	0	257,000	0.00	257,000	0	0	257,000	
DP 69 - Tribal TANF Maintenance of Effort											
02	0.00	51,031	0	0	51,031	0.00	51,031	0	0	51,031	
DP 70 - Regional Staffing and Operating											
33	3.00	0	0	97,500	97,500	5.00	0	0	162,500	162,500	
DP 81 - Additional Clients in Community Based Waiver											
22	0.00	330,245	0	797,255	1,127,500	0.00	557,615	0	1,306,073	1,863,688	
DP 83 - Wait List Reduction											
10	0.00	326,138	0	798,863	1,125,001	0.00	335,700	0	789,300	1,125,000	
DP 86 - Staff Training to Reduce Violence and Improve Comm											
33	0.00	35,000	0	0	35,000	0.00	35,000	0	0	35,000	
DP 90 - CHIP Donations											
11	0.00	0	500,000	1,978,929	2,478,929	0.00	0	500,000	1,899,232	2,399,232	
DP 95 - Montana Veterans' Home Contingency Fund Line Item											
22	0.00	0	250,000	0	250,000	0.00	0	250,000	0	250,000	
DP 101 - Prior Year Authority- Local Board Inspection Funds											
07	0.00	0	100,000	0	100,000	0.00	0	100,000	0	100,000	
DP 110 - Continuation of Hospital Provider Tax (Requires Legislation)											
11	0.00	0	8,640,550	20,859,450	29,500,000	0.00	0	9,078,326	21,263,674	30,342,000	
DP 111 - MT Tobacco Use Prevention Fund Switch & Reduction (Requires Legislation)											
07	2.00	183,992	(183,992)	83,646	83,646	2.00	183,991	(183,991)	83,412	83,412	
DP 112 - Expand Nurse First to Non-Medicaid Native American											
11	0.00	0	1,000,000	0	1,000,000	0.00	0	1,000,000	0	1,000,000	
DP 114 - Personal Assistance Base Restoration											
22	0.00	223,196	0	538,825	762,021	0.00	227,997	0	534,024	762,021	
DP 115 - Specialty Clinic Cost Recovery (Requires Legislation)											
11	0.00	0	200,000	0	200,000	0.00	0	200,000	0	200,000	
DP 116 - Montana Veterans' Home Replacement Vehicles											
22	0.00	0	85,000	0	85,000	0.00	0	0	0	0	
DP 117 - Clinical Laboratory Specialist											
07	1.00	0	45,880	0	45,880	1.00	0	45,752	0	45,752	
DP 118 - Eastern Montana Veterans' Home Flooring											
22	0.00	0	37,112	0	37,112	0.00	0	0	0	0	
DP 144 - Higher TANF Work Participation Rates - OTO											
02	0.00	0	0	1,850,000	1,850,000	0.00	0	0	1,850,000	1,850,000	
DP 145 - Energy Conservation and Energy Assistance Bien-OTO											
02	0.00	0	0	1,450,000	1,450,000	0.00	0	0	0	0	
DP 146 - Develop System of Care for Children											
11	7.00	0	0	1,116,289	1,116,289	7.00	0	0	1,865,615	1,865,615	
DP 147 - TANF Incentive Awards											
02	0.00	0	0	1,000,000	1,000,000	0.00	0	0	1,000,000	1,000,000	
DP 148 - TANF Diversionary Projects											
02	0.00	0	0	1,000,000	1,000,000	0.00	0	0	1,000,000	1,000,000	
DP 149 - Developmental Disabilities Program - Fed Authority											
10	0.00	0	0	1,000,000	1,000,000	0.00	0	0	1,000,000	1,000,000	
DP 150 - Restore Children's Therapeutic Services											
11	0.00	0	0	722,970	722,970	0.00	0	0	722,970	722,970	
DP 152 - Increased Federal Grants											
03	0.00	0	0	300,000	300,000	0.00	0	0	400,000	400,000	
DP 155 - Rural Access to Emergency Devices Grant											
07	0.00	0	0	275,000	275,000	0.00	0	0	275,000	275,000	
DP 156 - Comprehensive Cancer Control Program											
07	0.00	0	0	150,000	150,000	0.00	0	0	150,000	150,000	
DP 158 - Smoke Detector & Fall Prevention Grant											
07	0.00	0	0	145,000	145,000	0.00	0	0	145,000	145,000	
DP 159 - Statewide Emergency Preparedness Staff											
07	3.00	0	0	135,818	135,818	3.00	0	0	135,440	135,440	
DP 160 - Early Childhood Comprehensive System Grant											
07	0.00	0	0	100,000	100,000	0.00	0	0	100,000	100,000	
DP 161 - Libby Asbestos Program Staffing											
07	2.00	0	0	74,997	74,997	2.00	0	0	74,794	74,794	
DP 163 - Public Health Planner											
07	1.00	0	0	43,580	43,580	1.00	0	0	43,461	43,461	
DP 164 - Communicable Disease Monitoring Staffing											

New Proposals											
Program	FTE	Fiscal 2006				Fiscal 2007				Federal Special	Total Funds
		General Fund	State Special	Federal Special	Total Funds	FTE	General Fund	State Special	Federal Special		
07	1.00	0	0	40,207	40,207	1.00	0	0	40,098		40,098
DP 165 - Environmental Public Health Tracking Staff											
07	1.00	0	0	37,188	37,188	1.00	0	0	37,090		37,090
DP 166 - Adult Lead Reporting											
07	0.00	0	0	25,000	25,000	0.00	0	0	25,000		25,000
DP 167 - Food Stamp Outreach											
02	0.00	0	0	10,000	10,000	0.00	0	0	10,000		10,000
DP 168 - Bed Tax Funding											
10	0.00	800,000	0	0	800,000	0.00	800,000	0	0		800,000
DP 172 - Increase Funding for MT Disability & Health Prog											
07	0.00	0	0	450,000	450,000	0.00	0	0	450,000		450,000
DP 177 - Education and Training Vouchers for Foster Youth											
03	0.00	0	0	157,000	157,000	0.00	0	0	157,000		157,000
DP 178 - Social Services Stipend Program											
03	0.00	0	0	1,200,000	1,200,000	0.00	0	0	1,200,000		1,200,000
DP 187 - Environmental Laboratory Chemist											
07	1.00	0	0	45,880	45,880	1.00	0	0	45,752		45,752
DP 188 - HIFA Waiver - Medicaid Redesign (Requires Legislation)											
04	0.00	0	0	0	0	6.00	0	0	20,000,000		20,000,000
DP 189 - Waiver of Deeming (Requires Legislation)											
04	0.00	0	0	0	0	0.00	0	100,000	0		100,000
DP 190 - Medicaid Payment Error Rate Measurement											
08	6.00	56,551	77,917	134,468	268,936	8.00	(170,464)	325,800	155,336		310,672
DP 191 - Child Support Maintenance Funding											
05	0.00	396,345	(396,345)	0	0	0.00	392,078	(392,078)	0		0
DP 192 - CHIP Enrollment to 10,900 Children (Requires Legislation)											
11	0.00	937,253	(220,127)	1,739,771	2,456,897	0.00	789,099	424,471	3,056,212		4,269,782
DP 193 - Chemical Dependency Admin Fund Switch											
33	0.00	76,273	(76,273)	0	0	0.00	24,919	(24,919)	0		0
<b>Total</b>	<b>3.00</b>	<b>\$2,864,010</b>	<b>\$17,590,210</b>	<b>\$36,215,245</b>	<b>\$56,669,465</b>	<b>13.00</b>	<b>\$2,306,765</b>	<b>\$15,825,333</b>	<b>\$58,616,411</b>		<b>\$76,748,509</b>